GROWING INTO A MIDWIFE: 
A THEORY OF GRADUATE NURSE-MIDWIFE 
STUDENTS’ PROCESS OF CLINICAL LEARNING

A dissertation submitted to the 
Kent State University College and Graduate School 
Of Education, Health, and Human Services 
In partial fulfillment of the requirements 
For the degree of Doctor of Philosophy

by

Gretchen G. Mettler

May, 2010
A dissertation written by

Gretchen G. Mettler

B.A., Kent State University, 1974

B.S.N., Youngstown State University, 1982

M.S. University of Minnesota, 1984

Ph.D. Kent State University, 2010

Approved by

___________________________, Director, Doctoral Dissertation Committee
James Henderson

___________________________, Member, Doctoral Dissertation Committee
Joanne K. Dowdy

___________________________, Member, Doctoral Dissertation Committee
Claire M. Andrews

Accepted by

___________________________, Director, School of Teaching, Learning and Curriculum Studies
Alexa L. Sandmann

___________________________, Dean, College and Graduate School of Education, Health, and Human Services
Daniel F. Mahony
One of the goals of emancipatory education is using curriculum enactment as an attempt to achieve a democratic educational process, according to Dewey (1938/1963), therefore education is not merely preparation for the future, but rather the experience of democratic living. The American College of Nurse Midwives’ Code of Ethics reflects the value of this historically significant curriculum aim. The first and third mandates are most relevant for this study as midwifery students are covered by both. Little has been done to understand the curricular issues underlying what transpires in the clinical learning realm between the preceptor and the student.

This grounded theory study describes recent graduates’ perceptions of their experience of respect, equity and civility while they were students engaged in clinical practicum during their masters nurse midwifery education and to understand how they and the preceptors dealt with the hidden and null curriculum. Data collection methods included semi-structured interviews with nine recent graduates of master’s degree nurse midwifery programs, review of documents, and review of literature. Data analysis followed Glaser and Strauss’ methods. Accepted strategies to promote rigor were employed.
The nine participants reported varying degrees of feeling respect from their preceptors and others in their clinical settings. All participants reported feeling that they were treated with civility. Most of the participants felt they were treated equally with others.

This study explained the descriptive theory “Growing into a midwife: A theory of graduate nurse midwife students’ process of clinical learning”. The theory describes the students’ internalized thoughts and feelings they experienced as they become a midwife while simultaneously working to establish relationships with their preceptors and others and coming to understanding the nature of working in the clinical setting. Interpretation of the theory using oppressed group, feminist, and critical theories, and implications for nurse midwifery education, are described and recommendations for further study are identified.
DEDICATION

This dissertation is dedicated to my daughter Elizabeth (Liza) H. Mettler who has always had faith in me. It is also dedicated to my aunt, Nancy H. Mettler. I thank both of them for their unflagging love and support through out the years of this journey. This dissertation is dedicated to the memory of my mother, Dorothy G. Mettler, a remarkable woman, who showed me by example how to forge ahead.

ACKNOWLEDGEMENTS

The author wishes to acknowledge the mentoring, wisdom, expertise, encouragement and support provided by her committee chair, Dr. James Henderson, as well as the committee members: Dr. Claire M. Andrews and Dr. Joanne Dowdy. The author wishes to acknowledge assistance and clarifications given by Dr. Teresa Standing and Dr. Deborah Lindell; and the advice, insights, and keen eyes of Dr. Noreen Brady and Linda Matson, MLIS. The author also wishes to acknowledge the encouragement and support from many teaching and nurse midwifery colleagues.

The author wishes to acknowledge the participants in this study. These nine very busy individuals found time to meet with me and even invited me into their homes to further the excellence of nurse midwifery education.

This study was partly supported by a grant for graduate study from the American College of Nurse Midwives Foundation. The support of the members of the Foundation is gratefully acknowledged.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>DEDICATION AND ACKNOWLEDGMENTS</th>
<th>iv</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>The Research Problem</td>
<td>1</td>
</tr>
<tr>
<td>The Problem Statement</td>
<td>6</td>
</tr>
<tr>
<td>The Research Purpose</td>
<td>9</td>
</tr>
<tr>
<td>General Research Questions</td>
<td>9</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>10</td>
</tr>
<tr>
<td>Qualitative Research Methods</td>
<td>13</td>
</tr>
<tr>
<td>Significance for Nurse Midwifery Education</td>
<td>14</td>
</tr>
<tr>
<td>Summary</td>
<td>15</td>
</tr>
<tr>
<td>II. REVIEW OF RELATED LITERATURE</td>
<td>16</td>
</tr>
<tr>
<td>Introduction</td>
<td>16</td>
</tr>
<tr>
<td>Nurse Anesthesia and Medical Students</td>
<td>17</td>
</tr>
<tr>
<td>The Undergraduate Mentoring Experience</td>
<td>19</td>
</tr>
<tr>
<td>Students’ Experiences of Connection and Caring</td>
<td>21</td>
</tr>
<tr>
<td>Brown, Knox and Morgan Studies</td>
<td>24</td>
</tr>
<tr>
<td>Replication Studies of Brown Knox and Morgan Works</td>
<td>26</td>
</tr>
<tr>
<td>Success, Self-Confidence, Self-Esteem, and Anxiety</td>
<td>27</td>
</tr>
<tr>
<td>The Role of Hierarchy</td>
<td>33</td>
</tr>
<tr>
<td>The Preceptoring Experience</td>
<td>34</td>
</tr>
<tr>
<td>Summary and Conclusions – Review of the Literature</td>
<td>41</td>
</tr>
<tr>
<td>III. THE RESEARCH METHOD</td>
<td>43</td>
</tr>
<tr>
<td>Introduction</td>
<td>43</td>
</tr>
<tr>
<td>The Research Design: Approach to Grounded Theory Research</td>
<td>45</td>
</tr>
<tr>
<td>Initial Data Collection</td>
<td>46</td>
</tr>
<tr>
<td>Sample Recruitment</td>
<td>46</td>
</tr>
<tr>
<td>Description of the Sample</td>
<td>47</td>
</tr>
<tr>
<td>Data Collection</td>
<td>49</td>
</tr>
<tr>
<td>Documents</td>
<td>50</td>
</tr>
<tr>
<td>Data Management</td>
<td>50</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>51</td>
</tr>
<tr>
<td>Techniques of Data Analysis</td>
<td>52</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table
1. Description of Participants ................................................................................. 49
2. Example of Data Analysis ...................................................................................... 55
3. Level II Codes ...................................................................................................... 67
4. Level III Codes ...................................................................................................... 69
5. Growing into a Midwife: Core Constructs, Concepts and Categories .................. 118
CHAPTER I

INTRODUCTION

The Research Problem

Previous researchers of nursing clinical education have engaged with issues such as learner-identified characteristics of effective clinical teachers (Brown, 1981; Knox & Morgan, 1985; Hartland & Londoner, 1997). The effect of preceptor experience on role socialization of undergraduate students has been investigated (Clayton, Broome and Ellis, 1989). Learning nursing thinking has also been explored (Nehls, Rather & Guyette, 1997). However, issues in the clinical education of nurse midwifery students in the United States have appeared in only a few published studies. In fact, it was not until 2007 that a descriptive qualitative study was published about United States nurse midwife students’ negative perceptions of their clinical experiences (Hunter, Diegmann, Dyer, Mettler, Ulrich, & Agan, 2007). The curricular issues underlying what transpires in the clinical learning realm between the preceptor and the student have not been researched. When writers of clinical learning issues discuss problems and solutions in clinical learning they do not mention the hidden and/or null curriculum in the context of clinical learning. Research has not yet identified nurse midwife masters students’ perceptions of the issues of respect, equity, and civility. Further, there are no studies of how these key hidden curriculum issues affect the clinical learning milieu, and outcomes of that clinical learning process. That which is not thought of, but is everywhere, and all that is involved in socializing a student into a culture, is known as the hidden curriculum (Eisner, 1996).
Areas which have been consciously dropped or have never even been considered to be possible subjects for the curriculum make up the null curriculum. The effects of the hidden and/or null curriculum in the clinical education of nurses in master’s midwifery programs are important educational and curricular issues to be identified and addressed.

The American College of Nurse Midwives (ACNM) Code of Ethics (2005) (Appendix A) explains the first mandate for Certified Nurse Midwives (CNM) is to respect basic human rights and the dignity of all persons. The third mandate of the Code of Ethics is to promote and support the education of midwifery students. In the overt curricular activities of classroom and clinical setting, the first mandate is generally addressed as regards the clients receiving care. One assumes when an education program engages in teaching nurse midwifery students, those individuals are enacting the third mandate of the Code. This is perhaps easier to see in the classroom than in the clinical setting. In the clinical teaching/learning setting, how do the two mandates of the Code of Ethics relate to each other?

One line of curriculum studies, the examination and conceptualization of critical pedagogy, has led to analyzing the assumptions of power and hegemony in the educative process. The assumptions of who holds the power in the work place and the classroom, and who holds the power in establishing, developing and disseminating curriculum are significant considerations having enormous impact on students’ clinical learning. The issues of respect and equity (parts of the hidden and/or null curriculum), or how adults are treated as learners in the clinical setting by their preceptors, are demonstrations and representations of underlying hegemony and power. Critical theory is illuminated by the
consideration of justice, equality, liberation, freedom and compassion (Slattery, 1995, p. 193). Acknowledging the issues of hegemony and power in an adult educational situation can possibly lead to a transformation of the existing social order. Once the issues of hegemony and power are uncovered and understood, transformation, justice, equality, liberation, freedom and compassion may become possible. In nurse midwifery education, especially in the clinical setting, the issues of the existing social order, i.e. power and its uses, and hegemony and its coercions, has a direct effect on the preceptor-student teaching and learning interaction. Understanding the issues of the existing social order holds the promise for developing a more democratic and collaborative educational process. Education should provide an emancipatory view that encourages students to develop a social vision both for themselves and for the women and families to whom they give care (Slattery, 1995). As Dewey reflects, “every experience lives on in further experience” (1938/1963, p 27). The implementation of clinical education, the curriculum developed to enact the course of nurse midwifery education, affects how students experience respect, equity and civility in their clinical learning. This enactment of nurse midwifery education will carry on with the students into their work as certified nurse midwives, and into their own teaching of future generations of nurse midwives.

Brookfield (1995) notes, however, a teacher’s good intentions do not guarantee best practices. Reproduced in the act of teaching is the morality of teaching manner, style and tact (Hansen, 2001). An important moral requirement of the teacher is to be open-minded and indicate to students a willingness to consider their questions and input (Scheffler, 1960/1968). Open-mindedness, Green (1971) writes, is part and parcel of “the
manners of civility expressed in the institutions of free speech, due process, and freedom of dissent” (p. 220). Students must be treated with respect. The importance of subject matter wanes compared with the manner in which learning situations are presented and preceptors’ manners with students (Peters, 1963/1968; Fenstermacher, 1990). The manner, style and character of a teacher (preceptor) are “unintended influences . . . (that) are almost always present” (Jackson, Boostrom, & Hansen, 1993, p. 44). The “untaught moral lessons . . . (are) an ubiquitous outcome of the teacher’s work” (Hansen, 2001, p. 839), and are powerful lessons learned by the student. Tact, how a teacher protects a student’s vulnerability, prevents hurt, reinforces and builds on the student’s strengths, and develops what is unique to him or her, becomes a lens through which to emphasize the moral meaning in teaching (Van Manen, 1991). As Hansen (2001) emphasizes, often a teacher, or a preceptor, must act quickly, but the tact employed in doing so has a major influence on how the lesson is retained. Whether the preceptor is patient, attentive, thoughtful, and respectful, or not, the persons they are, are conveyed in their style and their tact, and this has enormous implications for the students they teach.

Learning theory research in the last 20 years has extensively investigated students as learners in higher education, but the focus has been mainly on undergraduate students. Researchers have identified characteristics of students as learners, attempted to identify how students learn, proposed theories of how students develop as learners, proposed factors that affect students learning, and studied students’ perceptions of variables affecting their learning (Menges & Austen, 2001). The findings suggest that students benefit from teacher concern and respect for the students, and that there is often a lack of
congruence between teachers’ perceptions of what they do, and students’ perceptions of what teachers do (Feldman, 1988; Negron-Morales, Vasquez-Rodriguez, & De Leon-Lozada, 1996). Many questions remain about how people learn, including understanding how teachers can better support students as learners, and while many of these projects demonstrate students appreciate “hands on learning”, the issues encompassed in clinical learning have received far less attention than classroom learning (Menges & Austen, 2001).

Nurse midwifery clinical education has been continuously provided in the United States by various education programs since 1929. Since 1978, nurse midwifery educational programs have used the Core Competencies for Basic Midwifery Practice (Appendix B) to guide development of curriculum. The Core Competencies identify the hallmarks of midwifery, theoretical knowledge and clinical skills nurse midwifery students need to attain to be deemed safe beginning practitioners. To achieve the clinical components of the Core Competencies, nurse midwifery students are placed in a clinical practice setting with a preceptor one-to-one to learn clinical skills, apply theory and classroom knowledge in practice, and to be socialized into the role of a nurse midwife.

In nurse midwifery education, the ostensible reason for clinical instruction is to learn and refine clinical skills. The expression and exploration of issues that are not obviously connected with learning and refining clinical skills are generally not overtly discussed when preparing preceptors or students for the clinical experience. Neither the student nor the preceptor may be aware of their true expectations for the clinical experience, and may be especially blind to this study's selected critical factors for
learning: being treated with respect, being treated with civility, if not with warmth, and being treated fairly and in an equitable manner by the preceptor and others in the clinical setting. In society when one is in a respectful relationship, civil relations are established and sustained, while equality in the relationship flows from the respect each of the parties has for the other. However, in a relationship suffused with unequal power, as in a preceptor-student relationship, these critical components of social interaction may be ignored.

While nurse midwifery programs balance the students between numbers of clinical experiences and quality of support and supervision from the clinical faculty, important factors that have an impact on learning are ignored. Students are placed in preceptors’ practices that are not prepared to be adjunct teaching facilities with volunteer preceptors who have not had formal preparation for teaching and who receive limited support from the academic institution. Students’ perceptions of the factors that influence their learning, such as being treated with respect and civility, equity in their relations as adult learners with preceptors and others, and how they have dealt with these issues, affect their ability to successfully complete the program, affect their attitudes toward the profession, and perhaps affect their willingness to participate in education when they become CNMs.

The Problem Statement

An important aspect of the historical aim of emancipatory education is the striving to achieve a democratic educational process through curriculum enactment. According to Dewey (1938/1963), education should not be preparation for a future democratic way of
life, but rather education should embody the enacted experience of democratic living. He writes:

Can we find any reason that does not ultimately come down to the belief that democratic social arrangements promote a better quality of human experience, one which is more widely accessible and enjoyed, than do non-democratic and anti-democratic forms of social life? (Dewey, 1938/1963, p. 34)

The ACNM’s Code of Ethics (Appendix A) reflects the value of this historically significant curriculum aim. As a matter of integrity, nurse midwives who adhere to the Code of Ethics must enact the three mandates that make up the Code. Two of the mandates are most relevant for this study. The first mandate states: “Midwives in all aspects of professional relationships will respect basic human rights and dignity of all persons” (ACNM, 2005). Because this mandate states “all persons”, the Code indicates to midwives how they should treat clients and students. The third mandate states: “Midwives as members of a profession will promote and support the education of midwife students” (ACNM, 2005). Since there is consonance between the first and third mandates, and because the three mandates are co-equal, the implication is that the education of nurse midwife students should be grounded in respect.

While the first mandate is integrated throughout midwifery client care, there are questions about how it is applied to nurse midwifery students’ clinical experiences. Client treatment is very clear and stressed in the overt curriculum. However, the integration of this mandate of the Code is not clearly articulated when it comes to the treatment of students, and may not be considered by the preceptors, thus assigning this feature of
professional socialization to the null curriculum. Because as a profession, there is nothing written about the enactment of the Code of Ethics in clinical settings, the study of graduate nurse midwifery students’ perceptions of their treatment in their clinical experiences is one way to study this null curriculum problem.

More importantly, how the third mandate is enacted by CNMs in practice needs to be examined. Many CNMs welcome students into their practices, recognizing that in order to perpetuate the profession, they must educate future generations. How the students’ perceive their position in the practices is the inquiry of focus. It is important to understand what the students learn from the clinical experiences beyond the acquisition of skills. It is important to hear the students’ perceptions of their feelings of respect, equity and civility while they were learning with their preceptors as no one heretofore has solicited the students’ perceptions of their treatment in their clinical experiences.

One could assume that because the Code of Ethics is a major foundational document of the ACNM there would be literature and dialog reflecting the enactment in clinical practice and in the clinical education of nurse midwife students. However, there is a dearth of information on how ethics are enacted in the clinical education of nurse midwife students. The fact that such a dialog has not yet emerged is further evidence of a null curriculum problem, and an indication that this problem is embedded in hidden curriculum concerns.

Not surprisingly, there is no nurse midwifery educational literature that supports critical questioning of curriculum enactment of the Code of Ethics. Two other nurse midwifery educators, Dr. Claire Andrews, CNM, FAAN and Dr. Patricia Burkhardt,
CNM, FACNM, confirm that lack of awareness and practical understanding on how to enact the Code of Ethics during clinical learning is a null curriculum problem (personal communication March 4, 2010). They also agree that this presents an important and intriguing problem of research (personal communication March 4, 2010).

The Research Purpose

The researcher wondered how the experience of democratic educational processes in nurse midwifery clinical education is enacted; therefore, this qualitative research project was designed to systematically understand recent nurse midwives’ perceptions and experiences with respect, equity and civility while they were graduate students in individual precepted clinical practicum learning experiences. A substantive theory of new understanding from the students’ perspectives using grounded theory methods was derived from interviews, documents and member checking related to the graduates’ perceptions of clinical learning. A more detailed discussion and justification of the research method is presented in Chapter III. The development of the substantive theory that emerged out this grounded theory research and the theory itself are more completely explained in Chapters IV and V.

General Research Questions

The following research questions will guide the investigation of this study:

1. How do the graduates’ perceptions of the preceptor’s expressions of respect, equity and civility influence clinical learning for nurse midwife students?

2. What meaning can recent graduates make of their clinical experiences with respect to the stated, hidden, and/or null curriculum?
Definition of Terms

Terms requiring definition for this study are: nurse midwife student, preceptor, experience, clinical learning, clinical midwifery practicum, hidden curriculum, null curriculum, respect, civility, and equity.

For the purposes of this study a nurse midwife student is a registered nurse who was enrolled in an American College of Nurse Midwives Division of Accreditation approved master’s program. A nurse midwife graduate is one who has successfully completed the master’s program, who may or may not have yet taken the national certification examination and who may or may not yet be working as a certified nurse midwife.

In the nursing literature, a preceptorship is most often defined as a one-to-one teaching “of a new employee or nursing student, in addition to her regular unit duties” (Shamian & Inhaber, 1985, p. 79). In nursing education, the preceptor model is often used “as an intense one-to-one, reality-based clinical rotation” (Pierce, p. 245) directed by a staff nurse for a nursing student. In this study, a preceptor is a CNM who may or may not have master’s degree, who is not employed in a faculty clinical practice. A preceptor is a clinically practicing CNM who has volunteered her or his time to work clinically one-to-one with a registered nurse who is enrolled in a master’s midwifery program.

Experience as it is used in this study involves practical knowledge, skill, or practice derived from direct observation of or participation in events or in a particular activity (Oxford English Dictionary). Therefore experience involves passive
(observation) and active (participation) activities and affects both skills and knowledge. In consonance with Benner’s 1984 description of experience, this definition is not confined to passage of time as experience, but rather is concerned with action and interaction. The actions of the process of experience involve “refining and changing preconceived theories, notions, and ideas when confronted with actual situations” (Benner, 1984/2001, p. 178). Continuity (prior and current experiences influence the person’s future) and interaction (past experiences interact with the present experience) work in relationship to produce experience. The actions of experience (Benner, 1984/2001), continuity and interaction (Dewey, 1938/1963; Neill, 2005) are personal to each individual, and will never be the same from person to person or situation to situation. Experience is reflected in the definition of clinical learning: the acquisition and expansion of knowledge and skills that contribute to the students’ growth attained through the midwifery clinical practicum.

The midwifery clinical practicum is comprised of the day by day and overall opportunities the clinical site has to offer students during the time students are working with preceptors. When the student is with the preceptor in the practicum, the content could include out-patient care (primary care, gynecologic, antepartum and postpartum care), and/or inpatient care, including screening for the presence of labor or antepartum problems, labor, birth and the immediate postpartum period.

For this study, the hidden curriculum is the implicit curriculum, the culture and values into which students are socialized (Eisner, 1994). The hidden curriculum affects what students learn (Eisner, 1994). The null curriculum encompasses neglected areas of
study that are not taught. These areas of the null curriculum may be consciously omitted from instruction or neglected due to habit, expectation or tradition (Eisner, 1994). Generally, the null curriculum has escaped consideration by those who are in charge of developing curriculum (Eisner, 1994).

The definition of respect is a concept of being, part of the conscience developed in becoming a nurse and is shown in actions and expressing care for others (Wilkes & Wallace, 1998). That is part of the definition for this study. There are also several definitions of respect from the Oxford English Dictionary (2006), which are appropriate for this study. Most especially the definitions of respect that include treating or regarding others with deference, esteem, honor and consideration, as well as refraining from inflicting physical or psychological injury, or not meddling with a situation are appropriate for this study (OED, 2006).

Equity, as defined for this study, embodies the qualities of fairness and impartiality, and dealing with others in an evenhanded style (OED, 2006). Caring is an important part of equity, as true caring demonstrates equal consideration for all people (Wilkes & Wallace, 1998). Equity arises from a connected relationship, just as caring involves a web of connection. Justice is another aspect of equity. When justice prevails, everyone is treated with equal consideration (Theis, 1988). Violations of justice include favoritism, prejudice and unfair evaluations, all clearly related to unequal treatment (Theis, 1988). There can be inequality in knowledge, skills or function, while sustaining an egalitarian student-teacher relationship, where the student is accepted as a person who is equal to the teacher in personhood (Gillespie, 2002).
For this study, civility is defined as ordinary courtesy or politeness, and exhibiting good manners, as opposed to rudeness of behavior (OED, 2006; Forni, 2002). Civility, a “gracious goodness” (Forni, 2002, p. 9), is a form of awareness that involves exhibiting restraint, respect and consideration in relations with others. Civility involves considering others’ feelings and trying not to hurt them.

Qualitative Research Methods

To date no instruments have been developed to quantitatively assess perceptions. Instruments developed thus far reflect the researcher’s interests and assumptions. Perceptions are best assessed by talking with participants and listening to their words.

The two general research questions of this study

1. How do the student’s perceptions of the preceptor’s expressions of respect, equity and civility affect clinical learning for nurse midwife students?

2. What meaning can recent graduates make of their clinical experiences with respect to the stated and hidden and/or null curriculum?

both involve listening to the participants’ voices. Qualitative research methods best address participants’ meanings, give voice to the participants, and allow the participants to frame critical issues in their own words. In addition, the interview methods offer the researcher access to the experiences of deeper processes (Creswell, 1998).

Qualitative approaches to research provide useful description when little is known about a group of people, an organization, or some social phenomenon (Glaze, 2001). There is very little published research about the experiences of nurse midwifery students. There is nothing in the particular areas of interest for this study, students’ perceptions of
the preceptors’ expressions of respect, equity and civility and what meaning recent graduates make of their learning in their clinical practicum.

In the context of learning in a preceptor-directed clinical setting, qualitative methods provide a means for focusing on people within their social and cultural context (Glaze, 2001). The aim of this study was to reach an understanding of the world of the student nurse midwife. Qualitative methods, through the inductive approach, will allow the concerns of the nurse midwife graduates to emerge and be identified, rather than reflecting the researcher’s interests. This study listened to participants who completed a challenging academic course of study, underwent role change and who have been socialized into a new professional role.

Significance for Nurse Midwifery Education

Grounded theory lends itself to the use of the feminist approach to data collection, analysis and theory development. This approach is appropriate to use for this study because understanding power relationships, struggles with social devaluation, and resistance to oppression are all at play in the professions of nursing, nurse midwifery and in education (Creswell, 1998).

Qualitative study results may be transferable. Therefore the understanding gained from this study may transfer to midwifery education programs, and perhaps to other advanced practice nursing programs.

A grounded theory method of qualitative analysis is supposed to identify processes. The data collection methods for this study produced a retrospective account, rather than an account of the experiences as they happen. Participants will forget useful
details about their feelings and perceptions as time goes on, however most of the graduates participated within four months of completing their program, and retained clear memories of their experiences. The retrospective nature of the data collection may be a positive for some participants, as they may have needed time to process the experiences before discussing them.

Summary

There is minimal published research concerning the experiences of nurse midwifery students in their clinical practicum. There is no published research about the hidden and null curricula in nurse midwifery education, nor any discourse within midwifery education on the enactment of the ACNM Code of Ethics. This study used the grounded theory method of qualitative research to examine recent graduates’ perceptions of and experiences with three key curricular concerns, respect, equity and civility, when they were students in preceptor directed clinical practicum.
CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

This study’s three key curricular concerns of respect, equity and civility, are derived from the critique of the assumptions of power and hegemony that is critical theory. Critical pedagogy, derived from critical theoretical precepts and applied to education, may give insight into how nurse midwifery students perceive their clinical learning experiences and their experiences with their preceptors and others in the clinical setting. Critical Pedagogy has the ultimate goal of implementing the Deweyean project of democratizing education, an admittedly utopian alternative to what exists presently (Kellner, 2005). A Critical Theory of education, as explained by Kellner, is built upon the process of critique by Kant, Hegel and Marx. Kant critiques “prejudice and ill-grounded ideas and requires rigorous reflection on one’s presuppositions, basic positions and arguments supporting those positions” (p.51). Hegel critiques one-sided positions, while working to develop “more complex dialectical perspectives that reject and discount oppressive or false features of a position, while emphasizing positive and emancipatory aspects” (p.51). Marx critiques “ideology and situates analysis of a topic within the dominant social relations and system of political economy” (p.52).

In the literature on nursing education from student perceptions, most published work is on students’ perceptions of mentoring, best and worst attributes of clinical teachers, student’s own perceptions of success and failure in clinical experiences, or student’s experiences with preceptors. Many of the articles about the student clinical
teacher relationships are only speculation and opinion, little is based on research (Davidhizar & McBride, 1985). The following literature reviewed for this study shows that research has focused on undergraduate students and their relationships with mentors, preceptors, and clinical instructors. An example from medical education literature is included, as is an example from nurse anesthesia literature. It is rare to find research literature addressing graduate nursing education.

Nurse Anesthesia and Medical Students

A nationwide random sample of 200 Certified Registered Nurse Anesthetist (CRNA) clinical instructors, 200 students and all education program directors received a survey based on effective clinical anesthesia instructor characteristics identified in 1982 (Hartland & Londoner, 1997). Of the total returned (370), 354 were used for analysis. Of the 22 characteristics listed on the instrument, all were perceived by all respondents to be very important or highly important, an extremely high level of homogeneity. CRNA students are Bachelor’s prepared RNs who are required to have at least one year of work in an acute care setting, and are enrolled in a Master’s program that is accredited by The Council on Accreditation of Nurse Anesthesia. These students should have experience and be more mature than undergraduate students who have been interviewed and surveyed by other researchers (Hartland & Londoner, 1997). CRNA students are similar to nurse midwife students in the United States in maturity and possibly experience. Both education programs have independent accreditation.

Kernan, Lee, Stone, Freudigman and O’Connor (2000) developed a 94 item survey from focus groups of third year medical students that identified teaching behaviors
which seemed to facilitate learning in ambulatory settings. For each behavior there are two questions: “Do you recommend preceptors use the behavior?” (Kernan et al. 2000, p. 499), and “How important is the behavior to your learning?” (Kernan et al. 2000, p. 499). This instrument does not have any identified reliability or validity. For this study, the instrument was given to 150 volunteers who had completed one month of an internal medicine ambulatory rotation; 122 were returned. Kernan et al (2000) believe they may have identified new behaviors that may be important for teaching in the ambulatory setting. Many of these behaviors deal with the issue of respect for the student: “holding preliminary discussions about diagnosis and treatment away from patients, delegating responsibility for the wrap-up discussion, delegating responsibility to the student to ascertain and interpret test results, and providing immediate feedback at the time of the patient’s visit” (Kernan et al. 2000, p. 501). A commonly used behavior that received the lowest ranking was having the student present the history and physical in front of the patient. Another limitation of this study, besides those identified above, is that using student opinion after a one-month rotation may not be the best predictor for effective clinical teaching. This study does demonstrate similarities with midwifery education. Internal medicine physicians agree to take students without compensation for their teaching activities, and attempt to be respectful of both patients’ time and students’ learning in a heavily scheduled day (Kernan et al, 2000).

The previous two articles describe students in professional programs. These programs, while different from midwifery education, are similar in that students’ clinical learning happens in a one to one relationship with a preceptor. The CRNA students are
situated in an in-patient setting, while the medical students were in an ambulatory setting. Nurse midwifery students are clinically taught in both settings. Similarly to nurse midwifery students, these students in professional programs are presumed to be older than bachelors or pre-professional nursing students, and have prior life and professional experiences.

The Undergraduate Mentoring Experience

Using a qualitative approach to describe and explain students’ perceptions of the mentoring experience in the second half of their last year of nursing education in England, Cahill (1996) describes the importance of the mentor’s attitudes towards the students. Cahill reports that the students consider “consistency, genuineness and respect” (1996, p. 794) very important. If those attributes were present Cahill writes, relationships with the mentor were regarded positively, regardless of whether the mentor did not meet the student’s needs in other areas. Cahill’s participants felt it was important for them to have “mentors who had time for them, listened to what they had to say, and respected their opinions” (1996, p. 794). In contrast to the important characteristics, Cahill offers numerous student identified examples of relationship problems with mentors, which included lack of contact, limited, late and negative feedback that often focused on student’s personal attributes, not on skill attainment, being ignored, not answering questions, unequal work load where the student felt she was expected to do all the mentor’s work, lack of support and advocacy for the student, as well as little acknowledgment of the student’s need for teaching and learning. This report is limited by inadequate description of the participants. Cahill (1996) never reports how many
people participated in the group discussion that formed the basis for developing the interview structure for the individual interviews, nor did she say how many individual interviews were accomplished. Also, Cahill acknowledges the possibility that those students “with an axe to grind” (1996, p. 797) may have chosen to participate in the study. Cahill (1996) qualifies this thought by noting that the students did describe varying quality of mentoring.

Gray and Smith (2000) explored changes in students’ perspectives of their mentoring experience in a timeframe spanning from before the experience was initiated through the three years of their nursing program. Prior to the experience, students thought the mentor was to “be there exclusively for them and could be disturbed at any time” (p. 1545), and be someone who would guide and support, as well as supervise them. Traits they were anticipating in the preceptor were “nice, approachable, be a good communicator, be understanding, allow them to try things, and be respected by other members of the (nursing staff)” (p. 1545). At the end of the program, students described a good mentor as being enthusiastic, friendly, approachable, patient and understanding and having a sense of humor. . . . Is a good role model as they are professional, organized, caring and self confident. . . . Is a good communicator, knowledgeable about the course, has realistic expectations of students, pace their teaching to facilitate the transition from observer to doer and gives regular feedback on the student’s performance. Will involve students in activities, make an effort to spend time with student, are (sic) genuinely interested in the student, has confidence and
trust in the student’s abilities and gradually withdraws supervision (Gray & Smith, 2000, p. 1546).

The qualities of a poor mentor are the absence of qualities of a good mentor. Poor mentors do not follow through on promises, may not be well liked by other staff, often delegate work to the student that the preceptor does not want to do, does not have expert nursing knowledge, “tend either to over-protect their student” (Gray & Smith, 2000, p. 1546) or overestimates the student’s abilities and has unrealistic expectations for the students. Poor mentors lack teaching skills and fail to plan for teaching, may dislike their job or the students, and “are often distant, less friendly, unapproachable and intimidate the student” (Gray & Smith, 2000, p. 1546). By the end of the program all the participants, but one, had experienced a poor mentor.

Students’ Experiences of Connection and Caring

Through interviews with nine students in the last semester of a BSN nursing program, Windsor (1987) describes the importance of interpersonal relationships, of the instructor having high expectations for them, to demonstrate professional behavior inclusive of ethical behavior and collegial support. Students reported they wanted the instructor to be “a nice person who cares about me as an individual” (Windsor, 1987, p. 153).

Dunn and Hansford (1997) used a mixed methods approach with 229 students in the second or third year of their nursing program to understand the students’ perceptions of their clinical learning environment. The Clinical Learning Environment Scale (Dunn & Burnett 1995), which has proven reliability and validity, was used. Qualitative data
was gathered in focus groups throughout the clinical educational experience and focused on students placed in known good or poor clinical learning environments. The area of staff-student relationships demonstrated how the students valued that they be accepted as members of the team, and that staff, not only RNs, be engaged in a teaching relationship with them. This study suggested the importance of the nurse-manager’s (NM) commitment to teaching, and the importance of the NMs influence on how the student is treated and valued on the unit. In addition NMs were appreciated for spending a lot of time teaching the students. When the student was recognized and valued, there was high student satisfaction with the experience.

Gillespie (2002) used qualitative methods to explore a description of students’ experience of connection in the student-clinical teacher relationship in a BSN program in Canada. All eight participants had completed at least one clinical course. Gillespie identified connected relationships between students and clinical teachers, which encompassed personal and professional components that were flexible, contextually determined and guided by the importance of the relationship to focus on student learning needs. Importantly, Gillespie’s participants identified that the relationship between student and teacher was egalitarian, and significantly, “the egalitarian nature of the relationship arose from an equality as people, and, notably, that this personal equality coexists with an inequality of knowledge and skills, or a functional inequality” (2002, p. 569). Gillespie (2002) identified processes that are essential for forming connections that develop into positive student-teacher relations: mutual knowing, trusting and respecting and communicating. The student’s perceptions of teacher’s competence, compassion and
commitment are important. Gillespie suggests that when a connected teacher has confidence in her skills and abilities as an educator and nurse, she is able to meet the students’ learning needs. Gillespie also suggests that the teacher can demonstrate compassion and commitment by “being emotionally and physically available” (2002, p. 571). Gillespie’s participants reported that because they felt connected to the teacher, feedback was valued and valid, contrasted with an unconnected teacher whom they felt they had to “please” by trying to give correct answers. Gillespie suggests that while the fit between teaching and learning styles is important, the fit between aspects of personality, interests, communication styles, background and values affect how connections are formed. This is a “complex interaction of aspects that comprise and influence the individuals who come together in relationship” (Gillespie, 2002, p. 573).

Hanson and Smith (1996) interviewed 32 volunteer junior nursing students. Using a phenomenological method, the researchers asked the students to tell them about a caring and then a not so caring interaction with a faculty member; both classroom and clinical teachers were described. Faculty members who exhibited caring behaviors were identified by students as those who listened to them and accepted and acknowledged the students as persons. Those faculty members made the students feel confident in and encouraged about themselves and that they had chosen the right field for themselves. “A not so caring faculty member has no time, is unavailable, hurried, insensitive, condescending, dismissive and disrespectful of students, (and is) sometimes perceived as rigid, defensive and not interested in whether or not the student learns” (p. 109). With a not so caring faculty member, students report “feeling lost, scared, rejected, discouraged,
powerless, cheated…and not understood. In consequence, the student loses interest in the class and respect for the teacher, and stops contributing, while worrying about future responses from the teacher.

Brown, Knox and Morgan Studies

One of the first research studies to address the issue of student perceptions of effective clinical teachers was done by Brown in 1981. She developed a questionnaire, gave it to 82 senior nursing students and 42 faculty members, established content validity for the tool and then published the results. There are 20 characteristics on the questionnaire, which Brown classified into three categories. Brown reports that students ranked teacher relationships with students highest, professional competence next and personal attributes third. The faculty rated professional competence highest, relationships with students next and personal attributes third. Brown (1981) statistically demonstrated incongruence between the baccalaureate nursing student and the faculties’ description of an effective clinical teacher.

Knox and Morgan (1985) had three groups, 66 university nursing faculty (49 returned 72%), 500 BSN students enrolled in all years of a BSN program (393 returned 78.6%), and 100 recent BSN graduates (45 returned 45%), rank their perceptions of the characteristics of an effective clinical teacher. They used the Nursing Clinical Teacher Effectiveness Inventory (NCTEI), which is a 47-item survey instrument of their own development with established reliability and validity. Knox and Morgan’s (1985) survey seemed to support Brown’s (1981) findings of the importance of interpersonal relationship for teacher and students. Knox and Morgan (1985) suggest that except for
first year students, every category of respondent ranked evaluation activities as the
highest category, while personality was ranked lowest by all groups. While faculty and
BSN graduates in the Knox and Morgan (1985) study ranked nursing competence as
important, students ranked competence as the lowest or second lowest category,
depending on class rank.

In a later study, Morgan and Knox (1987) attempted to identify those
characteristics which made a clinical teacher “the best” or “the worst”. The sample was
composed of 28 clinical teachers and 173 sophomores to senior students from seven
break the data down by class of enrollment in this study, which may have some
confounding effect on the results. Using the NCTEI, students and faculty identified many
common characteristics for best clinical teachers, while both groups identified other
additional traits (Morgan & Knox, 1987). There was less agreement between the two
groups on the characteristics of the worst clinical teachers. Students identified “worst”
characteristics as personality traits such as being unapproachable and lacking empathy, or
interpersonal skills such as not being able to communicate their expectations clearly and
belittling mistakes. Faculty’s perceptions were much different and centered more around
enjoyment of nursing, ability to communicate well, or issues with appropriate evaluation
of students, such as “inability to objectively identify students’ strengths and weaknesses,
and unable to help students organize their thoughts about patient problems” (Morgan &
Knox, 1987, p. 333). Faculty and students identified multiple “worst characteristics”: 
poor role model, judgmental, not open minded. These teachers failed to recognize their own limitations, or to use self-criticism constructively . . . (and) perceived as not having provided support and encouragement to students, and to have failed to create an atmosphere of mutual respect (p. 333).

Replication Studies of Brown Knox and Morgan Works

Using the Brown’s Clinical Teacher Characteristics Instrument with 11 sophomores, 77 juniors, 46 seniors and 23 faculty members, Bergman and Gaitskill (1990) report that the teacher’s ability to show interest in the “patients and their care” (p. 37) and instructor feedback became more important for students as they progressed in the program. Students also identified that the faculty member should be “well informed and able to communicate knowledge to the students” (Bergman & Gaitskill, 1990, p. 37) as well as making the student evaluations objective and fair. The faculty identified the ability to “convey confidence in and respect for the students” (Bergman & Gaitskill, 1990, p. 37), and “being honest and direct with students” (Bergman & Gaitskill, 1990, p. 37) as important. In agreement with Knox and Morgan (1985) and others, Bergman and Gaitskill (1990) report that the faculty, while indicating a sense of humor is important, ranked it low along with self-control and flexibility. As with other studies (Brown, 1981; Flagler, Loper-Powers, & Spitzer, 1988), Bergman and Gaitskill suggest that students consider the teacher’s ability to supervise without controlling or taking over to be important. The students selected the ability to “convey confidence in and respect for students” (Bergman & Gaitskill, 1988, p. 37) as important instructor behaviors, in addition to the characteristics all respondents identified.
Kotzabassaki (1997) in a replication study using the NCTEI set in Greece with 185 students and 31 clinical instructors did not identify any significant differences between the two groups. This report is in agreement with Morgan and Knox (1987). Li also reported in a replication study in 1997 using the NCTEI with 81 junior and senior nursing students and 10 nurse clinical educators in a Hong Kong nursing school (not a BSN program). Li did not note any statistically significant differences between groups of students or between all students and instructors on the ranking of the five behavioral categories (“teaching ability, nursing competence, evaluation, interpersonal relationship, personality” (p. 1257)). These findings generally agree with Kotzabassaki (1997) and Morgan and Knox (1997), reiterating the importance of treating students with respect.

Lee, Cholowski and Williams (2002) report age and experience to be significant variables affecting student’s perceptions when they used the NCTEI with 104 second year students, and 17 clinical educators. Lee et al. report that students 18-20 years ranked interpersonal relationships more highly than students 21 and 50 years. The findings suggest that older students ranked academic guidance more highly than the younger students and could take criticism better than younger students. In this study, younger students ranked evaluation more highly, but older students stressed the need for performance feedback that discusses their strengths and limitations (Lee et al., 2002).

Success, Self-Confidence, Self-Esteem, and Anxiety

Students in a diploma nursing program generally used internal attributes to explain their success in the clinical nursing area, and external attributes to explain the lack of success Davidhizar and McBride suggest in a 1985 study. The respondents were
191 students ranging from the completion of the first clinical course through completion of a third level course. The instrument used four causal elements based on Weiner’s attribution analysis of achievement, and two open ended questions to explain the student’s reasons for success or nonsuccess in the clinical area they had just completed.

Pagana (1988) designed a two-part Clinical Stress Questionnaire. The first part had open ended questions that asked the respondent to describe the clinical experience from the perspective of a new experience, including the stresses, challenges, and threats that were experienced, and to indicate the amount of stress they were experiencing. Part two was a 20-item inventory with scales for measurement of threat and challenge emotions with established reliability and validity. The 262 respondents were sophomore or junior students recruited in their initial medical-surgical clinical experience from seven schools of nursing. Using the scales, results suggest that students are more challenged than threatened, however the open-ended responses seemed to demonstrate threatening aspects of the clinical experience. For instance more than 200 students wrote about feelings of inadequacy and fear of making errors. Sixty-eight students described the clinical instructor as a threat. The respondents identified “intimidating, threatening, demeaning, impatient, strict, and demanding behaviors” (Pagana, 1988, p. 422), capable of lower self-esteem. Many identified the feeling that “the instructor is watching and evaluating my every move” (Pagana, 1988, p. 422), and resented being questioned, and “put on the spot” (Pagana, 1988, p. 422). The threat of failure was identified by nearly 15% of the respondents.
Over the course of two years, 155 baccalaureate students who had completed five to seven quarters of clinical instruction were given a questionnaire of 16 clinical instructor behaviors and two open ended questions to complete for an investigation of the development of self-confidence in nursing students (Flagler, Loper-Powers and Spitzer, 1988). Flagler et al. attempted to identify students’ perceptions of teacher’s behaviors that encouraged or thwarted the students’ self-confidence as a nurse. The behaviors identified for this study were drawn from previous studies including Brown (1981), but the investigators also added items they deemed relevant. There was no pilot to test the instrument, and the authors acknowledge the instrument did not have established reliability or validity (Flagler et al., 1988).

Flagler, et al (1988) distributed the questionnaires to the students at the time the course evaluations were done, and 139 questionnaires were returned; 123 students made written comments for the open-ended questions. The respondents ranked “gives positive feedback”, “accepting of students’ questions”, “encourages students to ask questions”, and “creates a climate in which less than perfect behavior at new skills and application of knowledge is acceptable” (Flagler et al., 1988, p. 344) most frequently, and cited these behaviors as helpful for self-confidence. Negative feedback was ranked as least helpful for self-confidence. “Instructor behaviors that enhanced the student’s self-confidence as a nurse” (Flagler et al., 1988, p. 344) included “categories of giving positive reinforcement, showing confidence in the student, encouraging and accepting questions, providing support, and giving specific feedback” (Flagler et al., 1988, p. 344).

“Instructor behaviors that hinder the student’s self-confidence” (Flagler et al., 1988, p.
344) included categories of “no feedback or negative feedback only, intimidation, and
distress about the student’s lack of knowledge or performance” (Flagler et al., 1988, p. 344). The authors further analyzed behaviors into five factors. Four of the factors, instructor as resource, instructor as encourager, instructor as promoter and instructor as benevolent presence were rated by 70% of the respondents as helpful. The evaluator behaviors were judged by the respondents to hinder self-confidence, but the students valued specific feedback, feedback that indicated they were thinking and acting correctly, and how to improve, and behaviors that indicate to the students a sense of support. Flagler et al. (1988) suggest that an instructor showing confidence and trust in a student is as important for self-confidence as giving positive feedback, and both findings suggest all students, even intrinsically motivated ones, benefit from positive reinforcement as was also noted by Windsor (1987). The findings of this study suggest that students’ self-confidence is constrained by instructors who linger around, and is helped by instructors who are present for a new or complex situation (Flagler et al., 1988).

Randle (2000) investigated self-esteem of British nursing students. Her sample started with 56 students, and over the course of three years ended with 39 participants, due to theoretical sampling. Randle reports the nurses’ use of negative experiences for social control of the students and patients. All the students gave examples of abuse of power and position by nurses who bullied those who were perceived to be vulnerable. How students perceived negative input and situations affected their self-esteem; sometimes the students expressed that they did not like themselves much and felt angry, anxious and stressed because of situations where they had not attempted to protect
themselves or others. Randle reports that instead of challenging the bullying behaviors, the students began to assimilate similar tactics into their own behaviors. Randle also reports that all of the participants described episodes of ridicule and “personal psychological repercussions” (Randle, 2000, p. 398). Ultimately, as the students progressed in their programs, they changed from people who described themselves as “caring, supportive, kind and being empathetic” (Randle, 2000, p. 399), to people who adapted to fit in to their situations, and internalize to “nursing norms” (Randle, 2000, p. 399). Randle (2000) concluded that this behavior results in the displacement of the patient from the centrality of nursing actions.

To determine nursing students’ perceptions of their self-esteem and fear of negative evaluations, before, during and near the end of a three-year nursing program, Begley and White (2003) used The Rosenberg Self-esteem Scale (Rosenberg 1965) and an amended Fear of Negative Evaluation scale (Watson & Friend 1969, Leary 1983) with 75 respondents from two nursing schools in Southern Ireland. Both instruments have established reliability and validity. When the researchers amended the Fear of Negative Evaluation scale they established reliability and validity for the new instrument (Begley & White, 2003). The Rosenberg Self-esteem Scale measures self-esteem from a sociological perspective deemed important by Begley and White because “a central component of self-esteem” in nurse education is “the social context within which nurses are educated” (2003, p. 399). The results of this study demonstrated a significant increase in self-esteem, and declining fear of negative evaluation as assessed by the instruments. This increase in self-esteem is in contrast to other studies. The authors
speculate that one reason may be due to the varied definitions of self-esteem (Begley & White, 2003).

Kleehammer, Hart and Keck (1990) wondered about “what specific clinical situations do junior and senior nursing students indicate as being anxiety producing?” (p. 184). To answer their questions they had 92 junior and senior nursing students respond to the clinical Experience Assessment Form, a tool which the authors developed and report to have validity and reliability. They also asked an open-ended question about what was the most anxiety-producing aspect of the clinical experience. Analysis of the results suggests multiple factors produce the most anxiety: the initial clinical experience on a unit and fear of making mistakes. Clinical procedures, hospital equipment, talking with physicians and being late were identified by the students as producing anxiety. “Faculty observation and evaluation were also situations that provoked anxiety” (Kleehammer et al., 1990, p. 186). The most common answer to the most anxiety-producing aspect of the clinical experience was a negative interaction with the instructor.

Cook (2005) suggests that teachers’ inviting behaviors such as showing respect for students, acting in friendly and trustful ways towards students, expressing delight with a clinical group, and making appropriate patient assignments all achieve reduced student anxiety in the clinical setting. Cook used the Clinical Teaching Survey, (Ripley, 1986) a 44-item instrument with content validity, and Spielberger’s (1983) State Anxiety Scale which also has reported validity. The sample was composed of 229 junior and senior students from 10 different baccalaureate nursing schools. Cook’s results suggest that the students’ anxiety levels increased when faculty used “disinviting behaviors, such as
acting in an impolite manner towards students, being difficult to talk to, and treating students as if they are irresponsible” (Cook, 2005, p. 160).

The Role of Hierarchy

Begley (2002) had access to all students (125) enrolled in midwifery in all the (seven) midwifery schools in Southern Ireland. Only 19 volunteers kept diaries for the initial 3- to 10-weeks of the clinical experience, while 31 other participants agreed to be interviewed three times during the 24 months of training. All the students participated in group interviews at 19-21 months into the program. The first 13 weeks of midwifery training involved classroom material. After that time, students were in clinical placement, considered to be part of the staff, and their learning needs were not acknowledged. The students identified a hierarchy for midwifery in Ireland, with junior students at the lowest point. While the Matron (chief midwife) did not seem to be much in evidence for most of the students, some Matrons were described as quick to criticize and reprimand for small offenses. All the students wanted to stay on the Matron’s “good side” for future employment and references. One of the students said: “Matron is taking crap from administration and the sisters (midwives) tend to take it from the Matron and they delegate it out to the staff” (Begley, 2002, p. 315). This illustrates how certain behaviors are perpetuated by example. Begley writes that the students’ relationships with the midwives were “much more negative than those they were used to, even from their nursing background” (Begley, 2002, p. 315). Begley concludes “it is almost as though the midwives in this study were attempting to prevent the students from learning how to become midwives in order to exclude them from the elite club” (2002, p. 315).
The Preceptoring Experience

“Preceptor” originated in 15th Century England to describe a tutor or instructor (Pierce, 1991). In reviewing the literature about preceptors and nursing students, several themes have been identified. The themes included student’s perceptions of facilitating and obstructing factors for learning in clinical practice, the student’s experience of preceptorship as it relates to learning, the student’s experience of the preceptor-preceptee relationship, the nurse’s experience of being a preceptor, faculty of record and student nurses’ perceptions of the preceptor experience, and preceptored student’s view of their clinical experience. These articles span a wide geographic distance encompassing the United States, Sweden, and Canada, and cover slightly different models. However, all of this research addresses only the pre-licensure, preregistration or baccalaureate student’s experiences, not the masters, post baccalaureate, or advanced nursing practice student’s experiences.

Ohrling and Hallberg (2000a), as part of a larger study, interviewed 17 student nurses who participated in a 20-week practicum with a RN preceptor. The students varied in experience from no nursing experience (first clinical course) to 20 years as a nursing assistant. In depth individual interviews began after 5 weeks of the clinical experience, and were conducted over the next 5 weeks. The purpose of this report was to gain understanding and interpret learning within the preceptored experience on a hospital ward for the nursing students. Ohrling and Hallberg (2000a) describe how the students needed time to discuss their learning needs with the preceptor which provided them with the opportunity to develop learning goals. The authors describe how the students were aware
of their learning needs to various degrees, and that all their learning was directed towards both increased competency and responsibility. As the students progressed and as their preceptors transferred increased responsibility to the students, the students came to consider a wider arena, which included theory, necessary skill sets, legal demand requirements, and ethical considerations. Ohrling and Hallberg (2000a) found that while different students progressed at different rates, the decision “to widen the students’ access to training in practice” (p.19) was arrived at mutually. Students expressed the give and take between the preceptor and student in “letting go” and “allowing them to make their own choices” (Ohrling & Hallberg, 2000a, p. 19) without jumping in or imposing time requirements. The students also described the importance of learning there are many ways to do the same task. Ohrling and Hallberg describe a balance between the “student’s desire to feel more secure, learn to have a wider view and be able to work faster and the preceptor’s awareness of the students’ need to have more time to think things through” (2000a, p. 19-20). Students also described emotional and bodily sensations while learning. When the students were received with acceptance and understanding, they were able to develop self-esteem and feelings of competence. Ohrling and Hallberg (2000a) describe that when students were unbalanced between their perceptions of their own abilities and internal and external demands, “they expressed feelings of such bodily sensations as discomfort, pressure, tiredness, hesitation, being overwhelmed, and unable to think clearly because of being tired” (p. 20). However, sometimes when learning was achieved, the student needed the preceptor’s confirmation, rather than trusting the bodily sensation of “knowing it in their bones” (Ohrling & Hallberg, 2000a, p. 20).
In an analysis of the preceptor-preceptee relationship, Ohrling and Hallberg (2000b) describe how “creating space for learning” was one of four overarching themes, which explains how preceptors effectively lay the foundation for the ongoing process of preceptorship. The students who felt their preceptor created a space for learning felt secure, and felt allowed to grow and to develop professional competence. Students expressed that the preceptor’s encouragement to ask questions allowed them to feel competent, and to then reveal their inner feelings of incompetence. Ohrling and Hallberg write that students appreciated being approached as individuals by the preceptors in “an authentic and genuine way” (2000b, p. 31); students appreciated that the preceptors exercised control not only by physical presence, but also by asking the student questions before during and after a learning situation. As the student progressed in competence, both parties acknowledged that the questioning demonstrated positive confirmation by the preceptor and supported the student in feeling competent (Ohrling & Hallberg, 2000b).

Ohrling and Hallberg (2001) developed a model for the meaning of preceptorship from the nurses’ perspective, after analyzing interviews with 17 registered nurses from two hospitals in northern Sweden who had been preceptors for third-year students. The model encompasses two major themes: “Sheltering the students when learning, and Facilitating the students’ learning” (Ohrling & Hallberg, 2001, p. 533), both of which showed that the preceptor actively acts as a support to the individual student in clinical learning, and actively works to avoid the risk of failure for the student. The Sheltering theme encompassed the dimensions of “Co-operating” (with students and others) and
“Valuing” (observation of and listening to the students) (Ohrling & Hallberg, 2001, p. 537). The Facilitating theme encompassed the pedagogical strategies of “Communicating” and “Task-orientating learning” (Ohrling & Hallberg, 2001, p. 537) for facilitating student learning. All of these dimensions have social, ethical and moral implications for the development of the student’s self-esteem and feelings of empowerment (Ohrling & Hallberg, 2001).

Lofmark and Wikblad (2001) analyzed the diaries of 47 students from two classes in two colleges in Sweden during their final semester of a 3-year program. This was part of a larger study that had originally included 60 students from the beginning of their programs. The purpose of this analysis is to understand student’s thoughts about facilitating and obstructing factors in the development of clinical competence. Lofmark and Wikblad (2001) identify four facilitating and three obstructing behaviors from analysis of the student’s diaries, and suggest many students identified value in being allowed to take responsibility, to work independently with the opportunity to practice different tasks, and to receive feedback. Students also valued good collaboration with staff. As Lofmark and Wikblad write, “These factors highlight the importance the students attached to the willingness of supervisors to engage in a teaching relationship” (2001, p. 47-48). Some students had the opportunity to supervise classmates, or newer nurses, and this bolstered their self-confidence as they showed them how to do something. The students identified serious “obstructing factors for learning” (Lofmark & Wikblad, 2001, p. 46) which included an inadequate supervisor-student relationship, including feelings of being treated condescendingly, lack of appropriate supervision, and
lack of feedback. As has been documented by others, for these students, when they do not feel accepted, learning is difficult, because they are expending an enormous amount of time and energy trying to fit in to the social group.

Nehls, Rather and Guyette (1997) interviewed 10 senior nursing students, 11 preceptors, and 10 faculty of record associated with a United States Midwestern university to understand the lived experiences of those who participate in a preceptor model of clinical instruction. Nehls, et al. write that the preceptors showed through their caring for patients that they cared for the students. This caring action was labeled by the preceptors’ “positive reinforcement” or “building up their confidence” (Nehls, et al., 1997, p. 224). The student perspective reflected that they were working with nurses who were dedicated to appreciating what they needed to learn in exact situations. Further, Nehls, et al (1997) suggest that the clinical learning environment with these preceptors reflects who the learner is and who the learner may become as they were with them in a caring relationship. The faculty of record encourage the preceptors to teach by “revealing their clinical thinking to students through practice and dialogue” (Nehls, et al., 1997, p. 225), which is a more powerful learning concept than getting particular skills right.

Factors that have an impact on the students’ clinical learning are important to the student experience. Peirce (1991) used a questionnaire of open-ended questions with 29 first and 15 second-level undergraduate students at Columbia University School of Nursing. The response rate was 50%. Of the students who responded, the students’ average age was 32 years, and 60% had another degree. This is a different cohort from groups used by other writers; however the findings are similar to previously cited works
on the preceptor experience. The first level students had a good day when they were
“treated as a student, and not as an aide” (Peirce, 1991, p. 248). Both groups commented
on the importance of positive interactions with staff and being able to spend time with the
preceptor. First year students had a bad clinical day when “the staff was not receptive”
(Peirce, 1991, p. 248), they did not receive feedback, or they felt alone. Both groups
commented that lack of contact with the preceptor, not given direction and only
observing contributed to a bad clinical day. The students expressed problems with the
preceptor program, including having a preceptor who is not confident with the role, is
inattentive, so the student feels alone, or does not seem to like the student, or when the
students were not able to practice what they had learned. Students also found problems
when the floor orientation was skipped, they were not evaluated, or they had feelings of
helpless. Detrimental learning was identified by the students when there was not
communication between the preceptor and the instructor of record, the student could not
find the preceptor, other staff nurses were not accepting of the student, or the student
perceived no direction from the preceptor.

Myrick and Yonge (2004) investigated the development of critical thinking skills
during preceptorship experiences for graduate students. This is one of the few research-
based articles on preceptorship for graduate students. Myrick and Yonge interviewed 10
graduate students and eight preceptors (two of whom were not nurses) in a total of 45
interviews over 3 years to discuss with them their roles and the meaning of critical
thinking. Myrick and Yonge first discuss the theme of the one-to-one relational process,
and the driving force, which could move the student forward, or hold the student back,
that “contributed directly to the development of critical thinking” (2004, p. 374). The authors describe the one-to-one relationship as “pivotal” to the success of the preceptorship, as well as to the development of critical thinking, and the student’s sense of achievement and competence. The researchers describe how both the preceptor and the graduate student bring “contextual particularities derived from their own personal and professional experiences” (Myrick & Yonge, 2004, p. 374-375).

Myrick and Yonge (2004) note of most particular importance is the power gradient, of which all participants were well aware. The preceptor’s power derived from her/his expertise. Further, it was the preceptor who made the choice to use the power. Myrick and Yonge (2004) describe how the students, because of their previous professional accomplishments and the confidence they derived from those experiences, were more able to be independent challengers of the clinical status quo. However, the students also felt vulnerable by virtue of their student role.

Myrick and Yonge (2004) also discuss role modeling “as a key ingredient in critical thinking” (p. 376). Students find the way a preceptor asks questions to be empowering or disempowering Myrick and Yonge note. However, most were able to rise above the power gradient of the preceptor relationship. One student said “I think at the graduate level, the practicum should be about what the student wants to learn, where the student wants to be, not just about what the preceptor wants to work” (Myrick & Yonge, 2004, p. 376).

In moving forward and holding back, Myrick and Yonge (2004) write about the need for baseline respect and trust and “a true spirit of ‘encouraging skepticism’” (p. 377)
in order for critical thinking to develop, for the student to “move forward in their thinking” (p. 377). Myrick and Yonge (2004) note that preceptors who are genuinely open to student input, and demonstrate respect for student opinion, and are flexible in their thinking are able to cultivate critical thinking in students. Students were unmistakable in expressing to the researchers that they had to feel safe with a preceptor in order to put forth their ideas, and pose questions. With trust, students are able to question and be questioned and to grow professionally in their critical thinking abilities. Without that trust, if the situation is more about pleasing the preceptor, it becomes problematic, and the ability for critique and dialog founder as the student becomes reluctant to express her perspective (Myrick & Yonge, 2004). Students explained that when preceptors made them feel inadequate, constrained and tense, the students feel shut down, unsafe, and silenced.

Summary and Conclusions – Review of the Literature

This chapter opened with a brief discussion of critical pedagogy followed by a review of the literature on nursing education. The literature reviewed addresses students’ perceptions of mentoring, student and faculty perceptions of best and worst attributes of clinical teachers, student’s own perceptions of success and failure in clinical experiences, and student’s experiences with preceptors. All of the literature addresses undergraduate or prelicensure students. Little of the literature on the student-clinical teacher relationship is research based; much is based on speculation and opinion. The literature reviewed for this study has focused on undergraduate students and their relationships with mentors, preceptors, and clinical instructors. An example from medical education literature was
included, as was an example from nurse anesthesia literature. It is rare to find research literature addressing graduate nursing education, a clear need for scholarly inquiry has been demonstrated. Older works uses quantitative methods. Many of the articles are replication studies. The more recent qualitative work has explored the issue of respect from the students’ perspective, but the issues of civility and equality remain to be studied.
CHAPTER III
THE RESEARCH METHOD

Introduction

One of the goals of emancipatory education is using curriculum as an attempt to achieve a democratic educational process, according to Dewey (1938/1963), therefore education is not merely preparation for the future, but rather the experience of democratic living. The ACNM’s Code of Ethics (Appendix A) reflects the value of this historically significant curriculum aim. The first and third mandates are most relevant for this study as nurse midwifery students are covered by both. The first mandate states: “Midwives in all aspects of professional relationships will respect basic human rights and dignity of all persons” (ACNM, 2005). Because this mandate says “all persons”, this includes how midwives should treat clients and students. The third mandate specifically states: “Midwives as members of a profession will promote and support the education of midwife students” (ACNM, 2005).

While the first mandate is integrated throughout midwifery care and education, there are questions about how it is applied to nurse midwifery students. Client treatment is very clear and stressed in the overt curriculum. However, the integration of this mandate of the Code may not be considered when it comes to the treatment of students, thus assigning that feature to the null curriculum.

How the third mandate is enacted by certified nurse midwives in practice is questioned. Most CNMs recognize that in order to perpetuate the profession they must
educate future generations, but how the students’ perceive their position in the nurse midwifery practices needs to be examined. Because it is important to try to understand what the students absorb from the clinical teaching experience beyond the acquisition of skills, it becomes important to hear the students’ perceptions of their feelings of respect, equity and civility while they were learning with their preceptors.

The nature of the problem stems from a dearth of information on how ethics are enacted in the clinical education of nurse midwife students, and that a dialog has not yet emerged for this issue. Not paying attention to the enactment of ethics in clinical learning is significant. Therefore, this qualitative research project was designed to systematically understand recent nurse midwives’ perceptions and experiences with respect, equity and civility while they were graduate students in individual precepted clinical practicum learning experiences. There is a lack of understanding of these key curricular concerns due to a lack of study of this problem.

The qualitative research methods of grounded theory were used to answer the following questions:

1. How do the graduates’ perceptions of the preceptor’s expressions of respect, equity and civility influence clinical learning for nurse midwife students?
2. What meaning can recent graduates make of their clinical experiences with respect to the stated, hidden, and/or null curriculum?

A substantive theory of new understanding from the students’ perspectives using grounded theory method was derived from interviews, documents and member checking related to the graduates’ perceptions of clinical learning.
The Research Design: Approach to Grounded Theory Research

Grounded theory is an exploratory method of research. It is an appropriate method when little is known theoretically about a given process. Grounded theory is appropriate for this study because it focuses on description and generation of theory (Creswell, 1998; Schreiber & Stern, 2001). Grounded theory, developed by Barney Glaser and Anselm Strauss, was first described in *The Discovery of Grounded Theory* (1967). Glaser and Strauss’ theory development uses the constant comparative method of data analysis. Comparing data for codes, categories and themes allows the researcher to discover theory of the basic social or basic psychosocial processes (BPP) of the situation.

Grounded theory is derived from sociological research. The original theoretical underpinnings of grounded theory stem from symbolic interactionism, a theoretical perspective that shows the relationship of people to society as “mediated by symbolic interpretation” (Milliken & Schreiber, 2001, p. 178), how people create and interpret their world. Symbolic Interaction assumes that everything has meaning conferred on it (Bogdan & Biklen, 2003). Rather than using psychological processes or philosophical theories to attempt to describe and predict behavior, Symbolic Interactionists use social processes of interpretation and social interaction. Grounded theory lends itself to the use of the feminist approach to data collection, analysis, and theory development. Grounded theory is appropriate to use for this study because understanding social processes, power relationships, struggles with social devaluation, and resistance of oppression are all at play in the professions of nursing, nurse midwifery, and in education (Creswell, 1998).
In working on this project, Glaser and Strauss’ original work (1967/1999) was a main reference. Additional methodological resources included Schreiber (2001) and Hutchinson (1993). Hutchinson’s processes have been adapted and heavily guide the description of the techniques used in this research project and the steps in this research process. The processes, which are discussed in detail in this chapter include: Initial data collection; Phase I analysis: Level I Coding, Level II Coding, Level III Coding; Phase II analysis: De-limiting the theory; and Phase III: Writing the theory. It is important to note that while the steps and processes are described in a linear fashion, the research project proceeded in an iterative fashion.

**Initial Data Collection**

Sources for the data collection included interviews, researchers’ field notes, documents submitted by participants, and member checking. The purpose was to gather large amounts of narrative data.

**Sample Recruitment**

After receiving Kent State University IRB approval (Appendix C), and approval from the ACNM Division of Research (Appendix D), the participants were recruited in several ways. First the program directors of the six nurse midwifery education programs in the Midwest who met the inclusion criteria for directing a master’s program that is primarily classroom based and that do not have a faculty practice were contacted by the researcher to recruit recent graduates. The program directors received a description of the project and were emailed a letter to disseminate by email to the recent graduates explaining the study, and asking for their participation. This recruitment, which involved
each program director contacting recent graduates multiple times, ultimately resulted in 10 potential participants. Two of the potential participants would have been phone interviews. Because saturation was reached before the phone interviews were arranged, the researcher elected not to conduct interviews with those volunteers. Two other interviews were not arranged due to schedule conflicts. One Great Lakes program director was never able to interest any of the graduates in participating; no program had 100% participation. The researcher also contacted the program director of an east coast program. The three recent graduates of that program all expressed interest, but one was unable to accommodate the researcher’s interview schedule. An additional participant from a different program was recruited by one of the participants. The nine participants are described in Table 1.

Data were collected from participants’ answers to an interview guide of open-ended questions about their experiences with clinical learning (Appendix E). The participants were interviewed once. One interview was conducted across two meetings, but lasted the same amount of time as the other interviews. The interview guide was initially formed by the researcher’s thoughts and review of related literature, and guided by issues raised during pilot study interviews in 2003. The guide was modified and changed as the researcher’s understanding increased with more interviews, and to validate the data analysis.

Description of the Sample

The participants fulfilled the criteria that they be newly graduated nurse midwives who had attended masters programs at either public or private universities that used
classroom-based programs where a faculty practice was not used for the clinical experiences. The participants were a purposive sample of master’s prepared nurse midwife graduates who graduated not more than 12 months prior to being interviewed from nurse midwife programs in the United States.

All participants were women. The ethnic diversity of the study was constrained by the graduates of the programs and participants who volunteered to be interviewed. While U.S. midwife programs are striving to admit diverse classes of candidates, the participants were middle-class Caucasian women, except one who was non-U.S. Hispanic. Participants’ previous life experiences varied from one who had been a nurse for 30 years to several who were graduate entry nurses and had never worked as a nurse. To protect confidentiality, minimal demographic information is being reported. Two participants were over the age of 40; all the rest were in their middle to late 20s. The Table 1 shows the student’s locations and their pseudonyms, along with their prior experiences and the interview setting.

Participation was strictly voluntary, and those who offered to participate were assured there would not be any consequences if they did not elect to participate. The proposal suggested that about 14 participants would be necessary for saturation, ultimately nine participants were needed. The sample size for the theoretical sampling was dictated by the analyses. On the whole, the nine participants offered a rich variety of examples of similar experiences. Theoretical sampling continued until the comparison of the categories demonstrated that they were mutually exclusive and covered the behavioral variations (Hutchinson, 1986).
Table 1

Description of Participants

<table>
<thead>
<tr>
<th>Program location</th>
<th>Participant name</th>
<th>Experiences prior to midwifery program</th>
<th>Interview setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Coast A</td>
<td>Linda</td>
<td>Teacher</td>
<td>Coffee shop</td>
</tr>
<tr>
<td></td>
<td>Maria</td>
<td>RN</td>
<td>Coffee shop</td>
</tr>
<tr>
<td>East Coast B</td>
<td>Felicity</td>
<td>Student</td>
<td>Coffee shop</td>
</tr>
<tr>
<td>Great Lakes C</td>
<td>Ann</td>
<td>Student</td>
<td>Restaurant</td>
</tr>
<tr>
<td></td>
<td>Bertha</td>
<td>Student</td>
<td>Restaurant</td>
</tr>
<tr>
<td></td>
<td>Emily</td>
<td>RN</td>
<td>Coffee shop (2 days)</td>
</tr>
<tr>
<td>Great Lakes D</td>
<td>Denise</td>
<td>RN</td>
<td>Coffee shop</td>
</tr>
<tr>
<td></td>
<td>Rachel</td>
<td>RN</td>
<td>Parent’s home</td>
</tr>
<tr>
<td>Great Lakes E</td>
<td>Carla</td>
<td>RN</td>
<td>Home</td>
</tr>
</tbody>
</table>

Data Collection

Each participant selected a date, and time in coordination with the researcher. At the time of the interview the researcher obtained signed consent for participation (Appendix F), for audio recording of the interview (Appendix G), and answered any questions. For the interviews, the researcher traveled to three Great Lakes states and an East Coast city. The participants all chose the interview venue. The researcher stressed to each of them that a quiet, comfortable, non-intrusive site would be best for the interview. However, most of the participants chose coffee houses for the interview, one of which
had an open-mike night, one of which was in the middle of a mall, and one of which was outdoors next to a bar. One interview was done in the participant’s home, another in the home of a participant’s relative. The interviews are confidential, and this was emphasized to the participants. The length of the interviews ranged from 40 minutes to 2 hours.

Documents

Data collection also included two types of documents. One participant submitted two papers she had written as class assignments. One participant submitted copies of her clinical evaluations for one semester. The participants were asked if they kept any written records of their thoughts and reflections while engaged in their clinical experiences. While a few said they had kept a journal, and offered to send it to the researcher, none did.

Data Management

The interviews were recorded using an Olympus MP3 portable digital voice recorder. The files were loaded onto a portable laptop computer; a back up copy of the interviews was saved on a CD-ROM, and another back-up copy was saved on a Toshiba 3Gb jump drive. Due to program incompatibilities between the MP3 model and the Windows operating system on the laptop top, four copies of the interviews currently exist. All but two of the interviews were transcribed by the researcher. The other two transcriptions were done by a friend, who was paid for her time. There was no time when the participant needed to be contacted to clarify any unclear statements. The researcher kept some field notes. Recorded field notes following interviews were transcribed and
kept with the interview. Handwritten field notes are stored with the hard copy of the transcripts. Researcher’s memos generated both by hand and in the computer have been secured in the researcher’s home office with the researcher’s journal of the study.

The transcripts were originally typed single spaced. They were then re-formatted with a large right margin for researcher notes. The lines were continuously numbered and the pages numbered.

Audio recordings, computer files and written records pertaining to the study were stored in the manner described in the Protection of Human Rights section of this chapter.

Data Analysis

The purpose of data analysis using the grounded theory method of qualitative research is to develop a theory. Using inductive reasoning, the theory is derived from the words of individual participants (bits of data), to a refined set of categories and their theoretical properties which are able to be generalized so that they become the characteristics of concrete entities (Glaser & Strauss, 1967). Glaser and Strauss do not provide specificity in the steps to be followed for grounded theory analysis. This researcher used the steps outlined by Hutchinson (1993) as a guide. However, that process was not completely helpful as the components are mixed up between steps for achieving increasingly refined categories and techniques for achieving the categories.

In the following discussion of the methods used for data analysis in this study, there are two sections: the techniques of data analysis and the description of the steps of the three phases used to refine and synthesize the emerging categories and their properties. The phases are (a) coding, (b) delimiting the theory at two levels: categories
and theory, and (c) writing the theory. In grounded theory since data analysis begins with the earliest data collection, the stages of data analysis and stages of coding discussed below did not occur linearly, but were intertwined.

Techniques of Data Analysis

In accordance with grounded theory procedures, the data coding began as soon as the data were available. Glaser and Strauss (1967), Glaser (1978) and Hutchinson (1993) describe seven processes of data analysis which were used for this study: (1) open coding, (2) constant comparison, (3) writing memos, (4) sorting, (5) theoretical sampling, (6) theoretical saturation and (7) member checking. While all processes were used throughout the analysis, one would dominate in developing a specific level of codes. Phase I: Coding, describes the processes of open coding, constant comparison, writing memos, sorting and member checking. Phase II: Delimiting the Theory discusses theoretical saturation.

Phase I: Coding

Coding, the fundamental technique of qualitative data analysis, refers to the classification of emerging categories, their properties and relationships. The goal of coding is to identify a Basic Social Psychological Process (BSPP) and its related properties. The BSPP and its properties, being derived from the data, are “grounded” in the data. BSPPs are discussed in detail later in this chapter. The coding, theoretical sampling and constant comparison for this study led to three levels of codes: Level I (in vivo or substantive), Level II (categories), and Level III (theoretical constructs) (Hutchinson, 1993).
**Techniques Used for Coding**

Open coding was the process used for the initial data analysis, this process led to Level I codes. The data were examined sentence by sentence, and were fractured into many categories and properties. During the open coding process the researcher asked “what is going on here?” (Glaser, 1978).

In constant comparison, incidents are compared back and forth to ensure that the behavioral variations are covered and that they are mutually exclusive. Constant comparison is a key process in developing Level II codes. The result of constant comparison is a number of categories.

Memos were the researcher’s notes of insights of theoretical ideas for the codes and their properties. Memos were added to and modified. Examples of memos are:

Students need to know the expectations of the site and of the preceptors.

Linda talked at three points about marking time as a student. Lines 59, 327 & 938. She mostly used it as a phrase for wanting to be done with the program.

Rachel also talked about just wanting to “get it over with”

Sorting was a process constantly used in coding and led to Level II and III codes (theoretical constructs). The data were sorted over and over as the researcher’s theoretical sensitivity developed. The Level III codes built on the researcher’s experience with and developing knowledge of the topic. As Hutchinson (1993) has noted, the theoretical constructs are used to model the connection among the three levels of codes. The theoretical constructs are based on and developed through substantive or theoretical codes, thus assuring that the theory is grounded in the data it has emerged from.
Member checking involved requesting feedback from participants about the findings of their individual interview summaries and the overall findings. While providing support for the correctness of the study, this is an important strategy for rigor of the study. Member checking was used during Phases I and III of the study. Details of the procedure used are discussed in those sections. An example of the data analysis process is found in Table 2.

*Level I Codes*

The primary process used to develop Level I codes was open coding and member checking. The process of Level I coding identified words, phrases, and/or sentences from each of the nine interviews. These words, thoughts, and ideas were identified by highlighting, margin notations and through memoing by the researcher. Because the researcher did nearly all the transcribing herself, she had the opportunity to re-hear each interview and obtained a flavor for the entire interview, noted the stories that were told and obtained an initial feel for the interview. As Sandelowski (1995) recommends, each transcript was read in its entirety several times. After reading the whole transcript, the first few interviews were then read in chunks, by whole thoughts or paragraphs, and then sentence by sentence to analyze for general similarities and differences. The process was repeated for subsequent interviews. The primary product of the open coding was individual interview summaries (Appendix H).
Table 2

**Example of Data Analysis**

<table>
<thead>
<tr>
<th>Quote from Participant</th>
<th>Level I Code</th>
<th>Level II Code</th>
<th>Level III Code</th>
<th>BSP and Construct</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 In a lot of ways I felt like a kid again because</td>
<td>Felt like a kid again</td>
<td>Vulnerable</td>
<td>Vulnerable</td>
<td>BSPP: Growing into a Midwife</td>
</tr>
<tr>
<td>23 you’re so vulnerable and don’t know anything.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 In some ways it’s hard to ask questions, because</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 you feel that you’re held to a certain standard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 because you’re an adult, and you’re expected to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 study and be devoted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 It was hard to sometimes know when it was</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 appropriate to move forward and take initiative to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 do something, or if I was being too bold or too</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 forward and doing something unsafely.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 As a student in clinical settings, the word I would</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 use to describe is vulnerable until the very end.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vulnerable</td>
<td>Proving yourself</td>
<td></td>
<td>Construct: Defining Self as a Midwife</td>
</tr>
<tr>
<td>82 Antepartum was with XX at two very vastly different populations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>83 There again, she was great.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>84 She’s just great</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>85 Always treated people professionally and with respect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>86 She never ever made me feel stupid.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>97 Never made me feel incompetent at all.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>88 She just guided me along.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>89 No question was ever inappropriate for her.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>98 She never made me feel that I was inferior, at all.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99 She knew how to teach and she led by example.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Construct II: Relationship: Establishing a relationship with The preceptor.</td>
</tr>
</tbody>
</table>
Member checking was accomplished by sending through email a copy of the interview summary to seven of the participants who could still be contacted. Each was asked to review her summary and decide if the summary was a good representation of her thoughts. Five of the interview summaries were returned. Each participant agreed the summary accurately reflected her thoughts and did not suggest any changes. The exact words of the participants were used for open coding to form initial categories and subcategories.

*Level II Codes*

The processes used to develop Level II Codes were constant comparison, memoing, sorting, theoretical sampling, and theoretical saturation. As the data collection continued, the researcher looked for data sources to fill in gaps in the categories. Data in this phase are used to find out what the incident indicates; how the incident compares with other incidents; and in what category are the other similar incidents (Hutchinson, 1986). At this stage Coffey and Atkinson suggest asking “What happens if…?” (1996, p. 50).

The purpose of the Level II coding was to reassemble the Level I codes at a more abstract level. The product of Level II coding was the development of categories and responses to the research questions.

The activities of Level II coding proceeded by making a continuous memo of thoughts and phrases, then cutting the memo, each of the interview summaries, and exemplar phrases from the interviews into pieces of individual statements or thoughts. Similar statements were grouped together in piles and sorted. The statements in the piles
were compared to each other and to statements in other piles. This sorting process of constant comparison continued until statements that were related were grouped together, and statements that were different were in other piles. Statements that were thematically related were put into brown business envelopes. Eventually the envelopes were labeled with a short phrase that described the envelope contents such as Marking Time or Respect. There are seven envelopes. These envelopes became Level III Codes.

**Level III Codes**

The purpose of Level III coding is to refine the emerging categories into theoretical constructs and identify their properties and relationships. Theoretical constructs (Level III codes), also termed selective coding, weave the data back together into the theoretical framework. Once the envelopes were named they were easily arranged, and the theoretical constructs arose fairly quickly. The final product of Level III coding is the emergence of a core variable or basic social psychological process (BSPP). The processes used during Level III coding, sorting and memoing, led to a BSPP: “Growing into a Midwife”. This BSPP “is processual in nature” (Schreiber, 2001), a characteristic that distinguishes BSPPs from other core categories. This BSPP has several other characteristics described by Strauss (1978, p. 36) including appearing frequently in the data; is central, links many other categories together and relates easily to other categories.

**Phase II: Delimiting the Theory**

Following coding, the second phase of grounded theory data analysis is delimiting the theory. As the researcher noted there were no new data adding to the categories and
the properties, she considered that theoretical saturation seemed to be achieved. In Phase II, the researcher synthesized the emerging theory at two levels: categories and theory. In this phase, the product is a theory that is parsimonious and of appropriate scope (Glaser and Strauss, 1967, 1999).

The researcher’s decision as to when to conclude the data gathering was informed by several considerations. Theoretical saturation seemed to be achieved. In addition several practical limitations including distances to travel, additional equipment to purchase and become familiar with for phone interviews, time, money, and energy all played a part. The researcher believed that given the constraints of the study, the fact that she intended to interview only the students and not preceptors or others at the clinical settings, and other constraints, an optimal level of theoretical completeness was achieved.

**Phase III: Writing the Theory**

Phase III of data analysis began once the BSPP was identified, theoretical saturation of the categories, their properties and inter-relationships was reached; and theoretical completeness was achieved. During Phase III of the data analysis, the researcher tried to integrate the codes, categories and constructs into a substantive theory of graduates’ perceptions of their experience of respect, equity and civility while they were students engaged in clinical experiences during their master’s midwifery education program. In accord with Hutchinson (1993), Schreiber (2001) and others, the researcher undertook to produce through this grounded theory data analysis “a dense, parsimonious theory covering behavioral variation” (Hutchinson, p. 206). The theory is described with the properties, conditions, strategies and consequences associated with it.
Techniques used in Phase III include member checks, revisiting the data and secondary literature review. The member checks involved sending through email a copy of Chapter IV to all the participants who had responded to the member checks for the interview summaries. Three participants responded, all had comments, most in the form of supportive statements. Revisiting data involved validating categories and their properties identifying data for a hypothesis or gap in the theory and to provide illustrations. As the data analysis and theory development progressed, the researcher reviewed appropriate literature for support for the emerging theory. Discussion is found in Chapter IV.

Rigor

Lincoln and Guba (1985) established the criteria for rigorous research: truth value, applicability, consistency and neutrality (Morse & Field, 1995; Creswell, 1998). To demonstrate rigor in qualitative research, they proposed four criteria that exemplify trustworthiness: credibility, transferability, dependability and confirmability. This study relied heavily upon the strategies for credibility and transferability that Lincoln and Guba (1985) have suggested.

Credibility

Qualitative research that is credible demonstrates “truth value”. This study followed three strategies suggested by Lincoln and Guba (1985) to assure credibility. The first strategy involved activities to increase the likelihood of producing credible findings. There are multiple ways of achieving credibility. The activity used in this study, prolonged engagement, provides scope through allowing sufficient time to understand the
“culture”, observing for misinformation caused by distortions of the self or the respondents, and building trust with the participants.

The second strategy for credibility was peer debriefing. Another skilled qualitative researcher, Dr. Noreen Brady, read three interviews and discussed coding and analysis with the researcher. The second researcher also discussed the categories and how the analysis came together to form the theory. There was a high degree of agreement between the coders. Consensus was reached, so the provisions for non-consensus coding did not need to be used.

The third strategy for credibility was member checks. Formal member checks were employed by having the participants read their interview summaries and by asking them to read a summary of the findings of the study.

Transferability

Transferability is demonstrated through “thick description” (Lincoln and Guba, 1985, p. 316). Thick description is the use of quotations taken directly from the interviews to illustrate the codes, categories or constructs. In addition, the reader has been given a general description of the participants.

Protection of Rights of Participants

The following strategies were employed in the study in order to protect human rights. The Institutional Review Board of Kent State University granted approval before initiation of the interviews (Appendix C). Because it was possible that some of the participants would be members of The American College of Nurse Midwives, the ACNM
Division of Research gave approval to contact members for this research project. The letter is Appendix D.

Each participant was read the consent forms prior to beginning the interview, and each participant was provided with a copy of the consent forms for the interview and the audio recording. Participants signed a consent form to participate in this study (Appendix F). In addition, the participants signed an audio recording consent form when they were interviewed (Appendix G). All participants understood that the opportunity to withdraw consent at any time was available to them. All participants chose to complete the interviews. Participants were each given $25.00 bookstore gift cards for each interview.

The researcher recognizes that financial reimbursement for participants is a controversial practice. Compensation was offered as the participants invested time and effort to be involved in the project.

Because the nurse midwifery community is relatively small, and use of real names might cause harm to the participants’ careers, many efforts were made to protect the participants’ confidentiality. To protect confidentiality, nearly every participant selected a pseudonym and was referred to by pseudonym in the transcript. Two participants initially did not select pseudonyms because their first names are very common. However, during the process of data analysis and writing, the researcher decided to give one of the participants a pseudonym. The pseudonym and participants’ names are noted in a continuous memo. The interviews are dated and recorded by pseudonymous name for reference. The memo of names and pseudonyms are filed separately from the hard and electronic copies of the transcripts. In writing the report, every effort has been made to
de-identify hospitals and agencies, cities and states. Preceptors are not referred to by name. Multiple attempts have been made to protect the participants’ confidences and their identities. Hard copies of the transcripts have been stored in an expanding (accordion) file in alphabetic order by pseudonym. When not being actively used in data analysis the transcripts have been securely stored in the researcher’s home office. The electronic copies of the transcripts are stored on the laptop and the jump drive and kept separately from the hard copies. All recordings of the interviews will be destroyed three years after the last publication associated with the study.

The Researcher as the Data Collection Tool

The researcher’s personal pre-conceptions, values and beliefs are identified as a means to try to promote objectivity and findings true to the data. These perspectives were “bracketed” during the proposal process. The researcher is a middle-aged woman of Northern European ancestry who spent the first 17 years of her life in a completely white community. However, she was raised by “enlightened” parents who stressed many positive aspects of difference. As a 15 year old, and again as a 17 year old, she participated with her church youth group in 2-week long missionary trips to Managua, Nicaragua and the remote highlands of Guatemala. These were seminal experiences, and ultimately have influenced both her career and lifestyle choices.

The researcher has been a Certified Nurse Midwife for 25 years, a clinical preceptor for over 20 years, and a classroom nurse midwifery instructor for 12 years. Her clinical experience spans a variety of settings including private practice, urban hospital clinic, community urban clinic, small city family planning agencies, birth center,
community hospital and a large urban teaching hospital. She has been a clinical
preceptor for family nurse practitioner, women’s health nurse practitioner and nurse
midwife students, as well as medical students and first year interns in both outpatient and
in-hospital settings. Prior to being a preceptor she did not have any educational
preparation for clinical teaching, but she has since attended workshops specific to clinical
teaching. The researcher’s perspective is colored by at least two things. As a student she
worked with a very frightening preceptor as well as many other wonderfully supportive
and nurturing preceptors. Also she has been a preceptor far longer than the two years she
was a student. The more remote the student experience becomes the harder it is to
remember what it felt like to be a novice.

The researcher’s prior knowledge of this topic stems from her current position as
a nurse midwife educator and program director. She has visited clinical sites from coast
to coast and talked with a variety of certified nurse midwife preceptors who work in a
wide array of settings. The education programs the graduates attended are known to the
researcher only by reputation, except for the graduates of the program the researcher
directs. Prior to this study the researcher asked two recent graduates to describe the
process of their learning to become a nurse midwife as a pilot project.

The researcher’s personal education as a researcher developed as this project
grew. As a novice researcher she worked with a research mentor who has used qualitative
methods for her nursing research. This research mentor acted as a second coder for a
sample of the data. They discussed this work extensively. Another peer reviewer who is
knowledgeable in nursing theory development and middle range theory was asked to
provide independent review of the developing theory. Working with these researchers helped improve the novice’s skills.

Other attempts to promote objectivity included discussing data and categories with another researcher, and using member checks to verify findings with the participants. The researcher also kept notes of reflections.

Summary

This chapter explained the methods of the grounded theory approach to qualitative research used in this study, strategies to assure rigor and trustworthiness, and measures to protect human rights. The researcher has followed the grounded theory methods of Glaser and Strauss (1967/1999) with additional input from Hutchinson (1993) and Schreiber (2001). None of the methods worked perfectly, and all were modified for this study. It is the goal to have a theory that is inductive, substantive and “grounded in the data”.
CHAPTER IV
RESULTS

Introduction

This qualitative, grounded theory study of recent graduates’ perceptions of their experience of respect, equity and civility while they were students engaged in clinical experiences during their master’s midwifery education included nine participants. The participants’ narratives about their clinical experiences are the principle form of data. Field notes also contributed to the data. The chapter reports how the data analysis was done, and the results are reported. From this analysis the researcher developed categories, concepts and a descriptive theory. The analysis answered the two general research questions identified in Chapter 1:

1. How do the graduates’ perceptions of the preceptor’s expressions of respect, equity and civility influence clinical learning for nurse midwife students?
2. What meaning can recent graduates make of their clinical experiences with respect to the stated, hidden, and/or null curriculum?

Results of Level I Coding

The results of Level I coding were the emergence of words, phrases, and/or sentences from each of the nine interviews. These words, thoughts, and ideas were identified by highlighting, margin notations and through memoing by the researcher. This process resulted in the production of individual interview summaries (Appendix H). The results of this initial coding then led to the activities of Level II coding. The interview question guide served as a frame of reference for the development of Level II codes. To
protect confidentiality, some information is reported as initials, has been given different identifiers, or is reported in ways to de-identify the participants (Chapter III). Five of seven participants responded to the summary which was emailed to them. All of them found the summary to accurately represent their interview and did not offer any corrections.

Results of Level II Coding

To achieve the results of Level II coding, each interview summary was read for similar phrases. Thirteen categories emerged. Some categories were composed of more phrases than others. At this point the categories were arranged in alphabetic order. The Level II codes were influenced by the interview questions, especially the codes of respect, equity and civility, as these issues were specifically asked of each participant. Two observations were noted in memos about these codes. The observations were: some codes seem related, perhaps can be combined; and some experiences might appear in two or more places and might be integrated into a new category. The results of Level II coding are shown in Table 3.

Results of Level III Coding

At this point the researcher collaborated with another qualitative researcher. The Level II code categories were worked with multiple times to understand how the categories related to each other and how they related with each other. The Level III codes emerged as seven major categories, some with subcategories. Most of the categories have many phrases, sentences or complete thoughts that illustrate them, while a few categories have a limited number of phrases. Each of the categories is illustrated by quotations from
Table 3

*Level II Codes*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Acknowledge Me as a Person</td>
<td>Preceptors need remember everything they say and do is being watched</td>
</tr>
<tr>
<td>2. Civility</td>
<td>Treating people justly and kindly</td>
</tr>
<tr>
<td>3. Equity</td>
<td>Universal treatment, how preceptors interact with everyone</td>
</tr>
<tr>
<td>4. Hanging on every word and action</td>
<td>Students observe preceptor closely</td>
</tr>
<tr>
<td>5. Honesty and Betrayal</td>
<td>The student thinks the preceptor is being honest with her, but later finds out the preceptor has been talking about her, or has reservations about her abilities.</td>
</tr>
<tr>
<td>6. Learning about the big picture</td>
<td>Multi-faceted; lots of things outside midwifery have an impact on the relationship.</td>
</tr>
<tr>
<td>7. Marking Time</td>
<td>Student going through the motions until she graduates</td>
</tr>
<tr>
<td>8. Preceptors take over</td>
<td>For some preceptors, it is easier to just do it than to watch someone else learn how to.</td>
</tr>
<tr>
<td>9. Proving Yourself</td>
<td>Showing preceptor and others I’m worth your time and efforts.</td>
</tr>
<tr>
<td>10. Respect</td>
<td>Basic requirement for relationship development</td>
</tr>
<tr>
<td>11. Shifting Sands</td>
<td>The rules change from day to day: the student never knows what to expect</td>
</tr>
<tr>
<td>12. Taking Initiative</td>
<td>Essential phase in student development into a midwife</td>
</tr>
<tr>
<td>13. Vulnerable</td>
<td>Student’s feeling, continues long into the process of becoming a midwife.</td>
</tr>
</tbody>
</table>
the interviews. Some important points were identified, but could not be put into a category. Some categories exist which do not have anything to do with the research questions and so are not developed for this study. The purpose in developing Level III codes was to refine the emerging categories and their properties into a more tightly organized and synthesized set of codes. By developing the Level III codes, the researcher was able to answer the two research questions. Table 4 lists the Level III codes.

Personal feelings of the Students

Vulnerable

Students in the clinical setting are vulnerable. As Emily said, “You’re really dependent on the preceptor for any sort of satisfaction or happiness that you get out of things!” Bertha added, “In a lot of ways I felt like a kid again because you’re so vulnerable and don’t know anything. In some ways it’s hard to ask questions”. The students described that feeling of being a child as coming from inside themselves. Linda reported “I felt like I was being treated like a child. Nobody meant to do that, I don’t think. That was me; that was my own thing.” Rachel described the child like feeling in a different way: “I feel like an eager beaver. It made me feel kid like, because that’s how my kids are. It made me feel youthful. Even though I’m tired, I’m still excited, I still have those butterflies about it”. Ann talked as a new student about how “I didn’t want to let her (the preceptor) down or have any kind of feelings that I was not able to perform the way she wanted me to”. Another student resisted enrolling in graduate school because she dreaded the learner-novice role she knew she would experience, “I don’t like making
Table 4

*Level III Codes*

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Personal Feelings of the Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Vulnerable</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Honesty &amp; Betrayal</td>
<td>Personal and experiential</td>
</tr>
<tr>
<td></td>
<td>Taking Initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hanging on every word &amp; action</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preceptors take over</td>
<td></td>
</tr>
<tr>
<td>2) Marking Time</td>
<td></td>
<td>Coping behavior/cognitive strategy</td>
</tr>
<tr>
<td>3) Proving Yourself</td>
<td></td>
<td>A step to be mastered along the way</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To the Preceptor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To others (physicians, nurses, patients, families)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrating program worth to the preceptor</td>
<td></td>
</tr>
<tr>
<td>B. The Students’ Relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Respect</td>
<td></td>
<td>Positive and negative experiences</td>
</tr>
<tr>
<td></td>
<td>Acknowledge Me as a Person</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respect &amp; Honesty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respect &amp; personal wellness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respect with other relationships</td>
<td></td>
</tr>
<tr>
<td>5) Equity</td>
<td></td>
<td>Everyone is treated the same way, well or not</td>
</tr>
<tr>
<td>6) Civility</td>
<td></td>
<td>Use of courtesy and respect, whether personally liked or not</td>
</tr>
<tr>
<td>C. The Outside World Affects the Students</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Learning about the Big Picture</td>
<td>Overt Curriculum</td>
<td>The external world</td>
</tr>
<tr>
<td></td>
<td>Hidden Curriculum</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Null Curriculum</td>
<td></td>
</tr>
</tbody>
</table>

mistakes and I don’t like feeling like I don’t know things.” There was a universal description of feeling of not knowing what you’re doing, and because of that feeling it
was important to hear encouragement and supportive words, and feel supported by the preceptors. Maria said,

I love when they tell you that you are doing good. I love when the preceptors give you feedback. Because many times you spend your life as fast as you can and you are there 12 hours worrying, trying to do your best, trying to be nice to the patient, trying to be nice to the attending, trying to be nice to the preceptor, trying to be nice to all the staff. And nobody tells you anything. So I love when you are trying your best, and they tell you that you are doing good. That would be a good day.

Ann reported “a day that I didn’t walk out feeling like a complete moron, or having issues with feeling inadequate” was a good day.

A bad day by comparison left Ann “feeling overwhelmed, and not having someone who supported me, or had me going off on my own”. Carla sadly reported:

getting to the end of the day and knowing that my preceptor was angry with me, or frustrated, or whatever the word was and not being able to get feedback to be able to understand what she wanted me to do differently. It felt as though many times her expectations changed from day to day. So that what I did right last week wasn’t right this week…I don’t know that the entire time I was with her she gave me one positive stroke. It was either negative or nothing.

This preceptor made it clear in multiple ways that no matter what the student did, it was not going to be good enough, consequently preying on her feelings of vulnerability.
Honesty and Betrayal

Some people have a difficult time being honest in their face to face interactions with others. Direct confrontation in a situation makes them uncomfortable. That type of personality in a preceptor makes for a difficult teaching situation as many students reported. The vulnerable student in the unequal power dynamics of the preceptor and student relationship is deeply affected by dishonesty. There are two outstanding examples among the participants of this study, Bertha and Carla. For intrapartum, Bertha was in a site with a preceptor her program had used before, but not for several years. Initially Bertha was told that she needed to come to the office for several weeks to meet the patients before she could attend their births. She did so, but the requirement stretched into the semester, and quickly she was seeing not just the women who were due to deliver soon, but all kinds of patients, both obstetric and well woman. It quickly became accepted that if they had a patient in labor while they were in the office, both the student and the preceptor would go to labor and delivery to check on the progress of the patient and then go back to the office to finish office hours; sometimes the student would be instructed to stay by herself with the laboring patient while the preceptor continued with the office hours. The office hours were never cancelled. When the course instructor came to the practice for a site visit, she saw them working in both sites, and so she asked the preceptor if she ever left Bertha alone on Labor and Delivery. The preceptor replied that she “didn’t think they were there yet”, although it had, in fact, been going on for several months. Under confrontation then, the preceptor did not tell the instructor the truth, perhaps to cover up the lack of supervision. Bertha accidentally overheard what the
The preceptor had said, along with some other critical issues that had never been raised to her. Bertha was left to wonder what else she was not adequately prepared for. The site visiting instructor was dumbfounded that the preceptor was alleging that the student was not ready to move along near the end of a critical semester nor had she alerted the midwifery education program to any possible problem. The preceptor had never discussed any of this with the student and in fact had given her very positive written feedback and had never given her any written feedback on areas for improvement. Bertha’s program was left to have her do some extra time with a trusted preceptor who deemed her fine for where she was. Bertha, of course “felt blindsided . . . I was so angry at the time, and very hurt”. In addition, review of Bertha’s clinical evaluations revealed only laudatory comments about her interpersonal interactions and encouraging comments about her skills.

Carla found herself with a midwife whose practice she had admired for a long time because it seemed to embody the philosophy she wanted to emulate in her practice. What happened was complicated, but from the outset it was not a good experience for Carla. On the clinical evaluations, the preceptor would mark Carla tenths of a point off, but never kept records on why she was marked off. All nurse midwives must practice under written practice guidelines, it is a professional standard. However, there were numerous times that the program and the student asked to see the practice guidelines and they were always told the preceptor was working on them at home; they were never produced. There were several labors the student participated in where there were early clear indications that the preceptor needed to consult with a back up physician, but she
did not do so until many hours later. This reluctance to consult modeled inappropriate professional behaviors including putting the clients at risk for less than optimal outcomes, and undermined the nurse midwife/physician relationship. Most telling, the preceptor while acting in a hostile manner towards the student would never tell her what she was doing wrong in her opinion, but she often called the program course instructors to tell them about the inadequacies of the student. Eventually the program removed Carla from the site, stressing that she had not failed, but that it was their judgment to move her to a different site. Once she acclimated to the new site, Carla was left to wonder what she could have learned if she had been at a site with a less hostile preceptor.

Rachel saw the issue of honesty played out in a very different form. She was witness to two midwives who had practiced together for a number of years separate into two different practices in two different hospitals about 50 miles apart. The separation was acrimonious; the midwife who was leaving attempted to influence patients to follow her to her new practice, draining her old practice of patients. Rachel also witnessed that midwife undermining her practice partner’s decisions to everyone, hospital staff, as well as the student. One night immediately after the midwife had terminated her privileges at her original hospital, she had a laboring patient who clearly would not be able to make the 50 mile drive to the new hospital, so she told her to have the baby at the old hospital. Instead of calling her old partner, she called Rachel and asked her if she’d like to come with her for the birth. As a fairly naïve and eager student, Rachel said yes, never thinking about the legal implications of being in a hospital with someone who did not have privileges to practice there. The ensuing aftermath was educational for Rachel and
showed her the importance of treating a practice relationship like a marriage, with respect for both partners, and how dishonesty can play out.

**Taking Initiative**

As students advance in their program, they experienced vulnerability in a different ways. They found themselves walking a tightrope between taking initiative and feeling they were too forward, or maybe even running the risk of practicing unsafely. Sometimes the student did not feel she could speak up and ask for more responsibility. Linda reported thinking

> We are students. You don’t get to say things when you’re students. The faculty always talked about how much power we have as students, and I completely disagree with that. I really didn’t feel that we had that much power. We were students, they tolerated us.

Students find it difficult to challenge the preceptor. Maria had a preceptor who she felt aggressively managed labor patients when Maria didn’t see the need, but Maria said

> I just felt I should do whatever she wanted me to do. I didn’t feel strong enough to say “no” to her and get into a huge fight. . . . Maybe I didn’t advocate enough. I wanted my clinicals to be nice. I want everyone to like me.

Several of the participants found themselves on unintended extended job interviews lasting anywhere from nine weeks to six months. As they realized that was happening, they found their attitudes towards the clinical situation changing, and consequently became timid about asking questions as they neared the end of their clinical
experiences. As Felicity mused, students already prone to second guess themselves, wonder if maybe “I should have known that. If I should have known that, would they not give me the job”?

Because of the vulnerability, the students remarked on the feeling of a safe environment for asking questions. Under the right circumstances, the students love having the preceptors quiz them. Rachel reported, “I had to think on the spot. It was a safe environment to be quizzed and to not know”. Maria felt the quizzing was beneficial “because I can demonstrate to them that I am on the right track. It can give them confidence, and then I can do it myself”. However, sometimes the environment was not so safe. Bertha once found herself “cornered” by her preceptor, and felt forced into giving an answer in front of a patient that should have been discussed in the hall. In that situation, there was probably no good scenario, the patient and the preceptor both needed the information simultaneously.

Felicity reports how “A lot of energy gets put into (getting to know the places, the people and the expectations) that could otherwise be directed to learning midwifery.” Maria confirms that if one is open to change, it will be ok.

Sometimes there is confusion because people do things in a different way. You’re working with one preceptor and she wants you to do it one way, then you work with another and it is a totally different way. . . . After you get to know everybody and how to work – it was ok.
Hanging on Every Word and Action

The participants, as Emily said before, are “dependent on the preceptor for any sort of satisfaction or happiness”, and because they are so dependent, they are sponges for all kinds of information; they ask questions, not just of their preceptors, but of themselves; and they observe nearly everything that happens in the clinical setting. They then interpret what was said or done, and because they are feeling vulnerable the meanings of what was said or done changes. Felicity asserted, “I’m watching everything she’s doing. That includes her interactions with co-workers; how many times she’s on the phone during the day. There are eyes on you all the time and I guarantee there aren’t many things that I miss”. Felicity went on,

We’re hanging on every word, we really are. There are eyes watching, there are ears too. They need to be gentle with their words. There were so many times I would replay a comment, what does she mean? What was she trying to really tell me?

In describing what would be an ideal preceptor, Felicity cautioned that the midwife should be aware that I’m watching everything she’s doing. That includes her interactions with co-workers. How many times she’s on the phone during the day. When she’s pissed with her husband’s phone call. There are eyes on you all the time, and I guarantee that aren’t many things that I miss. There’s a lack of awareness (on the preceptors’ part). There’s the invisibility issue. Sometimes it’s totally forgotten that there’s another person there. The preceptor needs to remember she’s a role
model. If I see you slack off and leave work early every day, it makes it harder for me to think I need to be there later every day.

She concluded that they are role models for the students, showing them how the profession functions.

Denise succinctly echoed Felicity while emphasizing the personal nature of evaluation and the relationship. She said the preceptor should be “very conscious that everything you (the preceptor) say is going to be taken personally to some degree or another (by the student).”

*Preceptors Take Over*

Some preceptors can not help themselves, it is just easier to “do it myself” than to watch a student learning how to do a task or handle a situation. Generally, one would expect to hear that preceptors take over more for students earlier in the student’s education, and far less frequently, or only when asked, later in their experiential learning. Most important is how the preceptor takes over. Is the taking over done in a way that the vulnerable student feels the situation was handled appropriately? Linda reported one preceptor usually “took over” during a birth, and “it was fine”. She enjoyed working with that preceptor and was with her a lot in her last semester

I loved working with (her), she was great. But I really never got to do an independent birth, just because her hands were always there. And almost after every birth she would say to me “I don’t know why I put my gloves on!”

Ann had an experience during her integration semester with a preceptor who was not used to working with her. The preceptor completely took over the birth, and “left me
as an onlooker for a birth and experience that I was really looking forward to and I thought that I was capable of performing”. She also had another preceptor who jumped in because, according to Ann,

they have a heavy patient load that maybe it takes me five minutes longer to write a chart, or five minutes longer to perform a physical exam. They take over because they’re concerned about (how long) their clients (wait).

**Marking Time**

Another personal theme that emerged was labeled “marking time” by one of the students. Marking time happened when the preceptor, for various reasons, did not allow the student the level of independence she felt she deserved at that point in her clinical development. Some of the preceptors did not allow that independence as a safety issue, while some preceptors just went ahead and did something themselves, because it was easier than having the student do it. When Emily began her intrapartum experiences with a preceptor she had spent the previous semester with (in the out patient setting), her preceptor insisted that she watch her for “a couple of births” before Emily could do one. Emily’s disappointment was intense: “I’ve been watching for seven years!” She recalled feeling very frustrated with the slow progression that semester. Emily acknowledged that her preceptor “just really took the reins for the first several patients, because I didn’t know what I was doing”. Rachel also reported she was “really disappointed”, when her preceptor’s hands were on top of hers for her first birth and thought “these are the ropes; what you have to go through”.
I knew it was a trust issue that she had to know that I knew what to do, so she
could hand over other births to me. I didn’t appreciate that as a student, because I
was very gung-ho as a student.

For Rachel, part of the marking time came from having so many things to do as
the mother of small children and all the attendant responsibilities. There were times when
she felt the preceptor did not honor her time commitment, having her stay when there was
nothing for Rachel to do, because the preceptor had to stay until 5 p.m. When offered the
chance by faculty in the program to go to school part time Rachel declined: “I’m getting
in and I’m getting this done.” While Rachel “couldn’t wait to get out of midwifery
school,” as a new graduate she wants to “encourage students to treasure this time when
you’re being midwifed through”; an important point to pay attention to. Students very
often are focused on the future, and want to just get done. Instead, as Rachel is pointing
out, they need to be present, or in the here and now with learning.

Linda reported marking time in a very negative way, without any up-sides, and
included many other students in her feelings. “We were students, they tolerated us. They
allowed us to be there because it is important to the profession and we were just marking
time.” Linda found some preceptors had a prejudice against her midwifery program. On
the days she was with those preceptors “I didn’t like to ask her too many questions, so I
just really marked time on those days”. There were days when Linda did not feel the
preceptors were letting her be as independent as she felt she could have been, which she
attributed to the preceptors’ comfort level with a student, so Linda spent the day sitting
and watching them, unless she demonstrated initiative to the preceptor, and made suggestions on work she could do. By the end of her program, Linda reported every minute was marking time; just do this one more day. One more day. One more day, and you can do the next day. Seriously, every day it was over, I would say “I only have 24 more days left to go. Then the next day was now only 23”.

*Proving Yourself*

All of the participants reported needing to prove their capabilities. This common theme permeated all the relationships the students formed in the precepted clinical environment, not just the relationship with the preceptor, but with nurses, families of patients, patients and sometimes doctors. This truly was an internal experience of the student. Ann reported with her first preceptor how she didn’t want to “let her down” by not being able to “perform the way she wanted me to”. However, the preceptor had never explicitly laid out any particular expectations for the student. Ann acknowledged the inherent difficulty for the preceptor of allowing someone else to care for her patients: “I think as a student you definitely have to prove you are worthy; that you do pass a few challenges or a few little tests or questions. Then you are able to prove you know something.” In Ann’s primary care semester, she felt she was not able to prove she was worthy to the physician preceptor, although she felt she eventually gained his respect for her abilities in the gynecologic areas of practice. For Ann, the feeling of proving herself happened over and over again, when she was able to successfully chart completely for a visit, when she could answer a casually tossed out question, when she could focus the microscope and then correctly diagnose a problem, and when she was able to provide
data and facts in a dialog with a physician to clinch the argument. Ann was acutely aware during her integration semester of being accepted as an outsider in a small community and as a student working with her highly respected preceptor the need to prove to the clients that she was “capable and worthy of their trust”.

Rachel expressed this theme of proving yourself in a different way. They would look to see, almost feeling you out. “Do you have it in you to do this? Am I wasting my time?” If they see you’re a gung-ho student, “I’m going to do this without your help”, then they totally give you 110%, all they can.

(Something) has to give them the “Yes! You’re dedicated to that.”

Rachel felt because she was working with physicians who were not “born and raised with” midwifery that she had to prove herself to them. Consequently she discovered the importance to thinking out loud, so that her actions were not misinterpreted. She also reported needing to prove herself to the families “almost every day. Yes, I’m a midwifery student, but I have some knowledge and skill and something to make it work.” As Rachel reflected on her growth through her midwifery program, she noted that because the preceptor accepted her judgment, she wanted to step up and speak up, and also to question things.

Both Denise and Rachel had to prove themselves as students on the Labor and Delivery floor to the RNs who were working there. Denise found if “you act like a normal person: ‘I’ll help you clean up the patient’, working like a team”: the issue of proving your worth to the nurses disappeared. Rachel found one day that she had to gently reprimand a newly graduated RN who was making assumptions based on hearsay.
After that incident, Rachel reported the problems were solved. Others reported greater or lesser degrees of needing to prove themselves to nurses, also.

Felicity noted “the difference between this (clinical learning) and a job was that every single moment of every day, I felt like I was constantly being, not assessed, but ‘on’ and yes, proving yourself”. After very unsatisfactory earlier program experiences, Felicity had a healing integration experience, and echoed Rachel: “As long as I came to clinical with a good attitude and a lot of effort, it was appreciated.”

Emily humorously admitted, “the first semester you don’t feel you are worthy of anything”, but she and others felt that they were granted more latitude than they were prepared for. Emily reported that her preceptors watched her practice on the first clinical day of each semester. When they saw that she could do what they were looking for, they then were available for questions, but did not observe her practice. “I think they had a little bit too much trust in the beginning (of each semester) right away”. Maria had similar feelings, “The first day they saw I was fine. And the second they were like ‘Oh, great, we love you! Can you imagine? I was in my own room! And the freedom!”

Having to prove yourself is stressful. As Maria noted “you have to be in your best moods, have your best face and be smiling. You have to prove all the time that you are good. It takes a lot of energy and takes a lot of time”. Emily noted humorously that the initial stages of every new clinical setting made her feel as if she didn’t “know a darned thing, so you just have to keep your mouth shut; watch what they’re doing and then imitate it with your clients”. Ann reported feeling overwhelmed, inadequate and unsupported sometimes. She and her first clinical preceptor did not communicate their
expectations well to each other, and Ann “didn’t want to let her down”. She describes the experience as “learning by being thrown into the fire versus being led by someone helping me”. Carla found after several months that the stress of going to clinical caused her to cry before she got there.

There are so many parts to prove! In the office, providing labor support, documenting, infant assessment and care. And the expectations of the program may not be congruent with the preceptor. Example: one preceptor expected me to tie suture with one hand because that is what she learned to do; another preceptor did not provide any well baby care so I was pretty much on my own yet needed her evaluation to pass. It never seemed to end. I felt as though I finished the program without ever having been accepted as a midwife.

Felicity noted “everyone expects that you practice the way they do. As a student, it’s exhausting to have to learn if you’re with so and so, she’s going to want you to do it this way; but if you’re with the other one, she’s going to want this to happen. After time you learn that, but to reestablish that every time you go to your clinical site is an exhausting process”. In addition Felicity lost sleep dreading going to clinical, and became ill from the stress of the personal interactions

Linda had a constant battle with the issue of proving yourself. For this student and for others there were two issues at play. The first centered around self. Many programs place midwifery students with a site, but not with a particular preceptor or preceptors. In that situation the student can try to select who to spend clinical time with, or the student can choose to attend clinical sessions regardless of who the midwife working that day
might be. Obviously problems arise with either scenario. For instance, a particular nurse midwife may not be particularly interested in being a teacher/preceptor. Another problem is that without a primary preceptor there is no one to observe the student’s progress. Linda reported that she thrives on responsibility, but being in a preceptored clinical situation made it easier for her “to not be as responsible as I would be. And they don’t expect me to be, really. At least that is what I felt, “because the ultimate decision rested with the preceptor”. Linda had a preceptor who said she didn’t like students from Linda’s program, so Linda decided she would never be able to prove anything to her.

Sometimes I felt like (I had to prove something), but I knew that was never going to work. I was never going to be able to prove anything. I was just trying to be able to do the best I could, but I needed to do better, if just for myself. I have had experience with other people and it never works, you cannot do that, you know. You just have to do the best you can, if they recognize it fantastic, if they don’t that’s it.

In dealing with the issue of proving herself, Linda seemed to choose the path of least resistance:

I did stay away from some people that I thought I was going to have to prove things to. I just didn’t want to do it, it just doesn’t work. They are not going to believe in you if they don’t want to. You just find the people that are open to it and you go from there.

Ultimately, by the end of the program Linda was glad to not have to face a preceptor every day.
There is another issue of proving yourself which centered around the particular program the student was enrolled in. Several students experienced the predicament of having to prove to their preceptors that their program was worthy. Carla’s preceptor had graduated from a program that was different from the one Carla was attending. Each program does things differently, but her preceptor became “mad” when she came to the clinical site with a different skill set from what the preceptor was expecting. She often told Carla, “In my program we did thus and so”. Linda and Felicity were judged as much by the program they attended as by their personal attributes. They were told that in the hierarchy of where students come from, their respective programs were at the bottom of the preceptors’ lists. No explanations, just that the programs, both of which are highly regarded nationally, were looked down upon by the preceptor pool. In the face of that discrimination the student struggled not only with proving personal worth, but also trying against steep odds to validate the entire midwifery program in the preceptors’ eyes.

The Students’ Relationships

The key concepts of respect, equity and civility that are the premise for this study emerged as the graduates talked about their relationships with their preceptors and others during their clinical experiences, and the process of how those relationships developed. Feeling respect is “internal” to the student, she feels the respect conveyed to her. By the same token, when respect is demonstrated, it is an external demonstration of the other to the recipient. This demonstration can be manifested at the minimum in civil interactions, or in a less superficial way through openness, valuing the other’s input and caring. Equity and civility are also manifested both internally and externally. It is apparent that the
expressions of equity and civility are external to the student: the preceptor treats everyone the same way, in an equitable fashion. The preceptor is civil when she is open and thoughtful in her dealings with everyone, staff, clients, consultants and students. While respect was the overriding concept, and came up in the conversations over and over, much more frequently than either equity or civility was mentioned, the three are intertwined. Respect is fundamental to human interactions and must be present for both parties for the relationship to flourish. There are numerous examples of this happening for these participants.

Respect

Rachel described a wonderful experience of being encircled with caring. “I was so honored to be in that situation that it was very exciting…almost as if I had a midwife to transition me through the situation”. Ann talked about her last preceptor, her integration preceptor who treated her as an equal, and not so much as a student. She was more than happy to learn from me, as much as she taught me. And that was very important. Versus being looked down upon, being treated as inadequate or incapable . . . she treated me as a partner, and not as a second rate student.

Ann’s final preceptor was not the only preceptor who treated Ann that way. Another of Ann’s preceptors, who was her preceptor for two semesters, “always asked me for my input . . . If a patient asked something and I knew the answer, or we collaborated on the answer she made me feel my input counted, and my thoughts were
respected”. Ann felt that her preceptor “treated (her) as a resource to learn from”. Emily reported all her preceptors treated her with respect, always.

They also treated me professionally. And I was held to a graduate level standard to be accountable for what I did and did not do. . . . They respected me enough that they treated me as an adult. . . . They were invested in my learning.

Bertha put her ideas a different way: “I can tell the people that love ob and who don’t. Those that do are respectful towards the patients, towards the situation, and towards the student and are comfortable people”.

Maria and Bertha both observed that the length of time someone had been a nurse midwife seemed to affect their ability to trust that the student knew what she was doing, and by extension display respect for her knowledge and abilities. Bertha said “the less experienced the preceptor is, the more they get their hands in things.” With one particular preceptor Bertha tried to negotiate the situations, “but she was in there. In the office she would do all the talking. When we had to call somebody, she was on the phone. It was her experience, not mine.” Maria echoed this problem,

There is one preceptor, it was her second year of being a midwife, so she was kind of new precepting people. She was really anxious, which made me anxious. She made me kind of crazy because she wanted everything perfect, and she was afraid I wouldn’t do the right thing. She jumped at me in the labors too quick. When I talked to her I told her that “every time I was going to do it, you jump and do it yourself”.
Maria said to herself, “I haven’t done anything bad with anybody else, so why don’t you give me time? When she talked with the preceptor about it the preceptor said ‘I think there is going to be a problem, and (I) think you’re not going to get it on time’”.

A respectful preceptor who worked well with the students “thought about the way in which I was learning. They would give me bits as they saw I was ready, they paid attention to me and my learning, rather than what they were saying and how they were saying it”, described Bertha. She went on, “They see my holes and have me acknowledge what they are, and have me acknowledge what I need to get to the next higher level”. Emily found her first preceptor would “select certain patients that were better for my learning than others.” In addition the preceptor was “always respectful of my time as far as the time it took to do a physical. When I was just beginning it took me an hour!” Another preceptor “raised the bar each week” for Emily regarding her expectations for competence in primary care. Denise said she was “very clear with everyone about what I know and I don’t know” and so she found her preceptors expected her to work at the level she was at, and not above it. “Everyone respected the fact that I would let them know if something was going on”. Denise seemed to create her own learning environment, “Just about everybody let me dictate what I wanted to do…So there were a LOT of things that I came up with to create a good learning experience”. She added that for her last semester, integration, “We were a team working collaboratively. Then I got to be a part of guiding what it was I needed to learn”. Linda had a preceptor who
was just so interested in making sure I had all of the resources that I needed, and she told me everything that was available to me, but I know all this, you know. She wasn’t trying to be super knowledgeable and show how much experience she had; she was just trying to be super helpful, but it was just too much for me.

So in the preceptor’s eagerness to “help” Linda become a good midwife by being helpful, Linda did not feel she was shown respect for who she (Linda) is and what she needed.

_Acknowledge me as a person._

All of the participants identified how important it was for the preceptors to acknowledge them as people first. Emily expressed it this way:

You get a very close relationship with somebody when you spend a lot of time with them. When you get into intrapartum and integration you get very close to your preceptor because you’re spending every waking moment with them, first of all. Those 3:00 am conversations. You get to be a part of each other’s lives for a temporary period.

Denise agreed that a respectful preceptor is someone who knows who they’re working with, and has taken time before they start the clinical to ask what’s your background, your schooling? Are you from the area? Do you live in the area? Are you new to the area? What about your skills, what are you confident in?
Also the midwives are welcoming to the student. The practice Denise was with for intrapartum invited her to their holiday meeting. “We had lunch, we did crafts, that was really nice”.

Felicity talked at length about the importance of being acknowledged as a person, “I felt more like an inconvenience and more ignored than anything, at times completely invisible”. During intrapartum she felt “it was clear that they didn’t really like me, or want me there.” During her intrapartum experience, she usually worked with a preceptor only about three shifts, usually because of how the midwives’ schedules were arranged vis-à-vis the students’ schedules. Out of all of the midwives she worked with, Felicity could identify two midwives who were not “mean” to her. “There was one midwife there who was actually cordial to me and treated me like I was interesting”. When Felicity worked with another midwife in the practice:

I thought it was so odd, we would eat our meals together and she wouldn’t speak to me. . . . I couldn’t believe she had zero interest in me as a human. I think she knew my name, I think she got that by the end. She had zero interest in me as a student, as a person.

Carla also experienced dehumanizing by her preceptor.

She never asked me a single question about my background, my philosophy, about anything! . . . I thought this will be ok, she’ll get to know me, this’ll be ok. I can work this out. But the bottom line is we never did.
Respect and honesty.

The preceptor’s honesty in dealing with the student is crucial. While all students perceived their feedback was honest, Bertha came to find out her preceptor evaluated her on paper one way, but talked to the course instructor about her in a different way. Carla had a different experience. Her preceptor would usually find her lacking in some instance, but the preceptor could never substantiate it. She also called the school to report the student’s deficiencies to the program without talking with Carla.

After Bertha felt destroyed by her preceptor’s dishonesty, she looked back at her journal and found that she had written multiple entries that said “I feel I’m not getting the feedback that I need”. She also reported the preceptor “was always very nice to my face. Always. And apparently she had some pretty bad things to say about me.” Bertha went on to muse, though that “she has a really hard time telling everyone to their face the things that she needs for the office to run smoothly. That doesn’t work in relationships of any kind, I’ve observed.” In contrast, Bertha found her other preceptors that had respect for her and that she respected “let me do stuff. They all trusted that I would come to them if I had issues. I think that’s really as far as student-preceptor relationship goes what respect is. Respecting that I am an intelligent person.” The preceptor’s lack of honesty in feedback embodies to the student and others a lack of respect for the student as an adult learner. Bertha said,

it goes back to did I feel she was being honest, and I had thought she was, but she wasn’t. It made me wonder what other things she wasn’t telling me that I needed
to be working on, and if I really had grown that semester. I didn’t know, cause I wasn’t getting the right feedback.

Later on when the preceptor said “you’re ok to go on. (It) was helpful, but didn’t carry much water.”

The dishonesty of Carla’s preceptor played out in different ways: “she complained a lot about me. She wouldn’t fail me. But she complained.” The faculty came to the clinical site and watched Carla with patients several times in the course of nearly a year.

They never saw me do a birth, but they saw me in the office because she complained so much about my lack of skills. They had me go with the Program Director and she said there was nothing wrong. So as far as my technique, my interactions, the Program Director never found any problem with it.

However, at the end of nearly a year of being with this preceptor, the decision was made by the program to remove the student from the clinical site. The preceptor had called again to complain about how the student had participated in and managed two long and rather complicated labors and births. The student had anticipated things the preceptor had not, and the student had identified a malpresentation in advance of the preceptor making the decision to call a physician for backup.

Respect and personal wellness.

A preceptor-student relationship without respect is debilitating for the student in both ego and energy, causing her to feel a sense of dread about the approaching hours to be spent with the preceptor. “I got to the point where I just would cry when I had to go to
clinical” said Carla. Felicity had difficulties in clinicals for several semesters with multiple preceptors, some of whom had been previously identified by other students as not being easy to work with.

I was having a really hard time (in intrapartum). I have trouble anyway reaching out for help, but I did, I reached out several times. I told them (the Program Director), this is not working, I don’t know how to fix it, but it’s not working. I am miserable. I hate going to clinical. I’m having digestive problems. I can’t sleep because I’m dreading going to clinical because of this personal interaction…I don’t know if I articulated well enough how bad it was. I thought I was saying it, and the response I got was not enough support.

Respect with other relationships.

There are other relationships in the clinical setting tangential to the student-preceptor relationship which also demonstrate respect or not much respect for the midwife students. Several students described relationships with nurses on the units where they did their clinicals. Other students described relationships with doctors. Denise found residents who worked in the same inner city clinic she did very helpful and provided more guidance than the assigned preceptor. Denise and Linda found labor and delivery nurses who would question their judgment and were a little harder to work with. However, Denise won their respect by being “laid back, talkative, non-hierarchical…When you’re one of them just act like a normal person, a human being. I’ll help you; working like a team. It went away.” Linda, on the other hand, who had never worked as a Labor and Delivery nurse before beginning the nurse midwife program found that “even
if I said something they would look at the midwife to make sure that looked right”.

Felicity had a nurse come to her almost in her defense, after she had been loudly and publicly criticized by her preceptor. “What did you do to her? She’s telling everyone on the floor you made a terrible mistake”. Without the nurse’s confirmation, Felicity would have spent the rest of the shift continuing to try to ignore the feeling that people were talking about her. Maria had the experience of having a chief resident make her cry twice. Once because the chief resident screamed at her that she was crazy because I was putting the patient at risk for cord prolapse. . . After that she went to all of the residents and they were talking about me and saying how crazy midwives were. So I went to my preceptor crying because everyone was talking about how crazy I am putting the patient and her baby at risk. The preceptor really supported me and she backed me up.

Sometimes in the course of teaching or correcting a student, respect for the student is diminished. Denise had particular problems with her first preceptor, a nurse practitioner, whom she described as “harsh, not very welcoming at all. Learn by scolding. Learn by embarrassment. You don’t know anything. You’d better shape up. I learned a lot, but it wasn’t a very pleasant experience”. In addition Denise reported that “there was a lot of talking down to me in front of the patient, a lot”. Specifically, Denise reported a time when she did not check a box on a lab requisition and the preceptor grabbed the form out of her hand, belittled her in front of the patient, and rolled her eyes. At other times the preceptor would “interject snide remarks” when Denise was talking with a patient. Linda recounted an embarrassing time when she was not prepared, after the
preceptor told her she really needed to know a fact, “she wrinkled up her nose and looked down”. Linda acknowledged that she really should have known the fact, but the way the preceptor treated her made it “really hard to get through the rest of the day”. In contrast, Linda reported, that on the whole she received good feedback, it was on-going and it was supportive. “I didn’t feel like they were trying to destroy me”.

Equity

Universally the participants agreed that most of the preceptors were equitable, they treated everyone the same way. Rachel and Maria both had preceptors who changed their lives, and as Maria said, that preceptor was super sweet to everyone. Rachel learned by word and example from her preceptor to “treat everyone equal and honor them”. Ann recounted fondly her experiences with her integration preceptor who treated her as an equal, she felt. “She included me as a partner, and not as a second rate student, which was very good”. Ann also thought it was important as a student to feel that you could share knowledge “and teach your preceptor something”. Further, Ann reported that most preceptors treated her “better than they treated their patients . . . on a more personal level. They were interested in my outside of clinical experiences, what I did, my personal life”. Rachel saw a preceptor who treated everyone well, but treated doctors very well. “I remember thinking, they’re just people. We’re all here, it’s all good. But she has her dynamic she has to work through”. Denise sometimes had physicians as preceptors and saw how they treated the residents. They would “say things that I thought were quite mean to the residents, but at the same time not ever say that to me”. Denise continued
Just about all the midwives I worked with had a really good working relationship with the patients, the doctors, the nursing staff, and that same level of respect was communicated to me. It was a team work, respectful approach, that everybody has a role to play and everybody is important. If we all work together and facilitate each other, the work’s going to get done well and right.

The first preceptor that Denise had, who had sneered and been condescending to her on occasion was never observed to be that way with patients.

Linda felt “they treated me like they treated everyone else”. Intense preceptors were intense with everyone, with the best of intentions. “I really didn’t feel I was treated differently” even with a preceptor who treated students disrespectfully, “I think she would have done that to almost anybody, not just me”, Linda concluded. Emily’s comments concurred. The preceptors “were pretty consistent. They were all very professional, well rounded, very nice people. They would treat their co-workers and talk to their staff just the same as they would treat and talk to me”. Carla concurred, her preceptors treated people equitably, although her primary preceptor was very touchy-feely with her patients. She was very down homey. She was very interactive with her patients. But once she was out of the room, that part closed. She was not open, not interactive, certainly not touchy feely.

Bertha observed

There’s one midwife I know I felt she was a little bit condescending. With her patients, she treats them like they’re five years old, . . I don’t know why that is,
because she’s a great person, and I like working with her, but she doesn’t treat her patients as her equal.

However, that preceptor always treated the student as an adult. Bertha also reflected on the preceptor who was not honest in her dealings with others: “She had a lot of nice things to say to people to their faces and a lot of not nice things to say not to their faces”.

For Felicity the expression of equity happened in different ways. “It’s not fair to put a student in a position to know negative things about students, or frankly be compared at all (to other students)”. At many of her clinical sites, the daily goal was only to get the patients seen and get through the day. In one setting however, “they all seemed energetic and really interested in giving the women the best care as possible”. Felicity noticed that on the Labor and Delivery unit, she was never introduced, especially to the doctors. So even if she had done all the work that was being presented to the consultant by the preceptor, she was not acknowledged. Felicity also noticed that some midwives talked down to the patients, especially if English was the woman’s second language. Between (the midwives) they felt very friendly. Amongst midwives, there’s a lot of nasty talk about physicians; to the physicians’ face, it often feels like sucking up.

So some of the midwives were not equitable in how they spoke of or treated their physician colleagues.

Felicity summed up the need for equity between preceptor and student this way: The most effective way for someone to approach me is that I’m their future peer. In a
year I could be working next to you, and treat me that way. Just because I’m behind you in the progression of this career doesn’t mean that I’m any less a person, or I deserve any less respect. I think many midwives have attitudes like, you’re just a student. Well, yes I’m learning how to be a midwife, but it doesn’t mean that I don’t deserve the respect of being your coworker or peer.

Civility

Every participant gave many good examples of appropriate civility in their preceptor clinical experiences. Just as most preceptors treat students with respect and are equitable in their dealings with everyone, most treated students and everyone else with open engagement and courtesy. Most preceptors could remember to greet people in the morning even without consuming the first cup of coffee. Most preceptors could engage in the small talk and niceties that lubricate social interactions. For most of the participants civility was so common place they did not comment upon it unless pressed. Bertha says, “It’s almost a personality thing. If those people are going to be like this in the office towards the patients, they’re going to be like this in the grocery store and to people elsewhere.” Denise also observed: “one person was a little bit condescending. I’ve gotten input from others that it wasn’t just me, it was her personality”. Linda concurred that a preceptor who made her feel “like I am just the stupid student here . . . just probably doesn’t notice, that is all.” She further confirmed it with some of the preceptor’s midwife colleagues who said “yeah, that is just kind of the way she is”.

Rachel watched incivility between the practice partners as the practice broke apart. While she did not directly feel the incivility herself, she witnessed how it played
out and affected the practice. Further, when Rachel and the maligned midwife were in the hospital together, the staff were continually questioning their judgment because the departing midwife had talked so poorly about her partner. This marred an otherwise great clinical experience.

Felicity once questioned a midwife’s directions in front of a non-English speaking patient in labor.

She was livid that I had questioned her authority. Proceeded to take me out into the hallway afterward, ream me for a good 5-10 minutes. Yelling at me in the open hallway about how foolish a person I was that I questioned her judgment. That I never think before I talk.

The preceptor also told everyone on the labor floor that she had made a terrible mistake. “It felt so immature and like a personal assault”. Felicity said with many of the preceptors “I felt more like an inconvenience and more ignored than anything. At times completely invisible,” because “a lot of the midwives didn’t make any effort to usher me into the community of the L&D floor”. When Felicity asked her program director for help with the clinical placement she was told an intervention “might make the situations worse, because you’re seen as the student who complains”.

Bertha reported receiving “The Tone” from one of her senior preceptors in integration. A younger midwife had described “The Tone” to Bertha and promised as a student she’d never hear it. However,

P. had “The Tone” when she wants you to listen to something and not because she thinks you’re not listening, but because she gets upset because something’s not
going right. She gets this tone in her voice. It means listen. I think she’s saying it cause she’s irritated.

Bertha reported “The Tone” as an example of how when things were not going well, and they were at the end of a long shift, her preceptor tried to maintain civility while experiencing frustration.

Emily recounted that her integration preceptor was sometimes more aggressive than I was used to with preceptors in how she would point out things. She was not disrespectful, but very aggressive with how she was talking, saying you have to do this. You need to do this. That was fine, I needed to hear that, but it didn’t make me feel like I was learning anything, but like I was being reprimanded, as a child. That was fine; I didn’t make that mistake again. However the process was a little uncomfortable.

Bertha witnessed another preceptor early in her first semester on a frustrating day explode:

I needed more time than she was able to give me, and I think it was frustrating for both of us. Things weren’t going well with office personnel. She threw things across the office, yelled at a patient, fired someone who she wasn’t allowed to fire, and all kinds of stuff. It was a really hard clinical day. I dreaded going back after that. . . . I felt I’m hopeless. I don’t know what else to do.

Maria felt she was treated with civility by everyone except the chief resident who had made her cry. The resident “screamed at me, telling me that I was crazy”.

Interestingly, the actual line of responsibility should be through the CNM preceptor and
the resident should not have any authority to criticize patient management decisions directly to the student, much less belittle the midwifery student. Maria was relieved her preceptor backed up her decisions, but she should not have been surprised.

Carla reported that while everything seemed to go badly with her preceptor she was civil with her. However

it felt as though we never ever connected on any level. Sometimes I’d ask her a question and she’d just cut me off. She wouldn’t even listen to the question. She was a person that didn’t bother with the niceties. She didn’t say good morning. Her persona was almost two different things. The face that the patients see and the face that goes with others are incongruent.

The Outside World Affects the Students

Learning About The Big Picture

Learning about The Big Picture has many facets, most of which are hidden to the preceptors and the students. Some preceptors make a point of describing big picture issues such as understanding professional issues, organizational hierarchies, revenue streams, and legislative agendas, but few apparently explicitly discussed how to manage the day to day issues. What emerged through the interviews was a consistent theme in student understanding of how to maneuver through the midwifery world. Some participants were very clear in their descriptions of what they saw in how to manage a clinic day. Some participants were surprised to find out what was needed to be successful working on the labor and delivery floor. While all but two participants, upon direct questioning denied being given any big picture issues, it is possible to identify in every
interview how they learn about the big picture. In addition, even when the participants denied learning anything, they learned how to avoid being in cross-fire, and strategies to survive, if not to thrive.

For antepartum and intrapartum clinical rotations, Emily’s primary preceptor was a woman who has practiced over 30 years and who owns her own practice with her partners.

She always treated people professionally and with respect. She never ever made me feel stupid. Never made me feel incompetent at all. She just guided me along. No question was ever inappropriate for her…She knew how to teach, and she led by example.

Emily further affirmed that the preceptors that I was with were happy in their roles, happy with what they were doing. They were satisfied with what their jobs were. So that makes it easy for them to like their patients, to like how they were going about each day. I think when they can be satisfied with that situation, they can also be nice to a student. And it helps with teaching another person.

Emily stated that she learned “everything” from her preceptors. Everything, right down to how to talk with the patients…Professionalism stuff. How to run an office and be part of an office that runs smoothly. Financial stuff. Insurance reimbursement. . . . Making sure we had appropriate documentation so we can be reimbursed. In the L&D realm with my primary preceptor, she just sat
there and watched. Wouldn’t really intervene too much, was just kind of relaxed about things.

In talking about the Big Picture, Emily discussed the importance of keeping education age appropriate and remembering screening tests. However, she also talked about the lessons of conserving energy when faced with responsibilities of running an office and being up with a woman in labor during the night. “You can’t just focus on the moment; you have to think about the next couple of days”.

Bertha’s integration was with the same midwife Emily had for antepartum and intrapartum, and she had similar experiences.

(She) really worked with me as far as role development as far as midwifery goes. She and I would have really long conversations about the art of midwifery. I don’t think she was telling me this because I did things wrong. I think she did it to enhance my experience. She would say things about relationships with patients, and not just a “it’s important to connect with your patients” kind of way; it was a much deeper, holistic connection. I think it’s a midwifery wisdom that she tried to instill in me.

Because Bertha was doing her integration experience, one of the practice partners would have Bertha see the patients independently and present the cases to her. Bertha reported that

(I) managed the office. Towards the end, she would sit in the office and do her own paperwork for the whole day, and get caught up on the office, while I saw all the patients. She would come to me and say “What are you doing? You’re three
patients behind!” That was stressful, but it was helpful to know that she was
cognizant of what was going on.

Bertha identified characteristics in three preceptors who she said understood
teaching and learning.

They didn’t just talk about clinical stuff; it’s more about the clinical picture. That
stuff was never neglected with those preceptors; that stuff those people paid
particular attention to was the details. They always seemed to have a more holistic
perspective of the entire patient. They seemed to have broader world
views…When I say the big picture, I’m not just talking about stopping at the
clinical big picture. It goes far beyond that. It helps me knowing that these people
are wise in ways beyond clinical situations. . . . They’re good at what they do
because they understand that, and they tried to help me understand that.

Bertha acknowledged that she also learned big picture lessons from preceptors she
did not like as much, including the importance of knowing what you do not want to be.

She explained

I don’t want to be fake to my patients. Patients know. . . . Not having a
fundamental love for (midwifery). . . I got to learn all kinds of stuff (about
practice pressures). There were all kinds of issues between the different midwife
groups at the hospital, and between the doctors and the midwives there. It was a
fabulous leaning experience in that regard. I’ve never seen so much controversy
in my whole life!
In her first semester Felicity found herself in a practice that had too many patients to see without enough time. They used the student as another staff member, the problem being she did not have the knowledge and experience to function as a staff member at that point. When she appropriately went to a midwife with a question she was often told “I don’t have time. I just don’t have time”. While the midwife was appropriate with the student in her interaction, the student felt the patient was punished because she then was forced to wait another 30 or 45 minutes for the visit to finish. At that clinical site, if the patient’s care was fairly straight-forward the midwife never saw the patient with the student. In addition there was even one day both of the midwives left, and I was still there charting. It was so bizarre. All the patients had left, of course, but I was still there charting. The charts were just left for the next day for them to sign off! It felt wrong to me that I was left in a clinic alone because they wanted to get home.

Felicity experienced staff chafing to go home at the end of the day many times. This made her wonder about what is important:

Making sure every clinic patient gets seen. Whether or not she had a good visit, whether or not she learned anything at her visit was secondary to “she was seen”. Maybe she waited three hours, but we saw all the patients. It was charted. . . .

How big a concern is it, that I don’t make any mistakes, or that I do her visit in 10 minutes?

Felicity also watched midwives who looked to her as if they were engaged in an endurance thing: I’m going to get through the shift, and I’m going to get
through my career as a midwife. . . . If they don’t like what they’re doing, they
don’t like teaching it either. That doesn’t make for a good student experience if
your preceptor doesn’t want to be teaching, doesn’t want to be there, or wants to
be home, or doing something else.

She summed it up

If I see you slack off and leave work early every day, it makes it harder for me to
think I need to be there later every day. Be aware that you’re a role model for how
this profession functions.

Maria had a preceptor who “was tired all the time. She was like ‘Fine. OK. Come
on let’s go home’ kind of thing, or complaining about the patients”. Another of Maria’s
preceptors frequently complained about hospital policies and protocols that she had to
follow.

Most of the time she was right. I knew she was right, and most other people
agreed with her. But in my mind, if she doesn’t want to follow the rules and she
doesn’t want to be here and she doesn’t want to work in the hospital, that is going
to affect everyone else. . . . The more she complained, the more she felt tension
and the more people were against her. So her job was more and more difficult as
she complained more and more. She is a great midwife, she did everything right,
but no policy or place was working (for her).

On the other side, Maria’s first preceptor for her well woman experience “really
changed my whole view of midwifery. One of those moments that you fall in love with
them and you really want to be like her.” Maria said the most important thing she learned from her preceptors was to love the profession, and that midwives are hard workers.

Linda’s preceptors showed her how to “really focus on the women as the patients. They were very adamant about the women making the decision and not anybody else, not their mothers and whoever”. Many of the women were not native English speakers, so this cornerstone of nurse midwifery philosophy was harder to manage.

Linda, as many other midwifery students, never worked as a labor and delivery nurse. The issue of unit staffing and numbers of patients a nurse had to care for was not important to Linda the way that knowledge would be to someone who had worked on a labor and delivery unit, and indicates a piece missing in the big picture for her. In addition, Linda had to learn about the importance of team communication. She came to eventually realize communication with the doctors is very important.

Just letting them know where we are. I tend to (think) “I know what is going on why does anybody else need to know”? I started to realize in the setting where we were that it is important for the doctors and the residents to know what is going on. They would get (upset if we didn’t). Nothing good comes of that.

Rachel who had worked for some years as a labor and delivery nurse before entering school and while enrolled had her eyes opened up to appropriate physician consultation:

There was a time she (the preceptor) consulted with the physician. She was very “by the guidelines”, at two hours you consult. The physician came in assessed it and didn’t take over. He said “yes, you’re doing properly, and I agree with you”,
and that opened my eyes. The beauty of a good consulting physician. Because I remember thinking that any time we consulted, the physicians took over, and I had thought would that always happen?

Felicity was told by one insecure preceptor that she “was never to speak to the attending physician again. Seriously? What if I had to consult?” The issue arose in a discussion over appropriate treatment for a common pregnancy problem. The student turned to the physician who was sitting with them to include him in the conversation, and asked for his opinion. “She got mad at me for that because she thought I was over stepping her position as my teacher in asking the attending”. The suffocating weight hierarchy, power and insecurity has on understanding the big picture are demonstrated here.

Rachel learned many things about cultural understanding and client-centered decision making, and that her own agenda was an insignificant part of the big picture. As with many students, prior to her nurse midwifery education program enrollment, Rachel had limited interactions with non-white, non-middle class people. Rachel holds strong Catholic beliefs. “It was really hard for me to talk about contraception with people”. Not only was that hard, but she had a tough time figuring out how she could be a good midwife “if I can’t address this huge piece called family planning?”. Her well woman preceptor encouraged her to discuss her dilemma with her priest.

He was very much that I can not make moral decisions for people. I’m responsible for presenting options and it’s their moral decision to choose, or to choose nothing. So that gave me great peace…I used to think to be a good
Catholic I couldn’t put in an IUD. I realize now that it’s their choice, and I need to respect that and provide that service.

She praised her preceptor for respecting her beliefs. From that preceptor and especially her intrapartum preceptor Rachel had reinforced to her the importance of treating everyone equally and honoring them. The intrapartum preceptor, a living legend in midwifery, showed Rachel how to be humble and quiet and it’s all about serving women. . . . I just loved how she was so humble and unassuming and just did what needed to be done. So I would try to imitate her in a lot of things.

Rachel found preceptors who desired to pass on the skills and traditions of midwifery suited her best; and she learned the importance of connecting with others in service to women and families. “I wanted to be sure I was learning the best way to be a midwife. So I had to kind of look at the whole situation and think how I would do it”.

Rachel realized by the end of her education that she would step up and speak up. As an RN I was advocating for the ladies, but you know you always defer, it’s not your responsibility primarily. As a nurse midwife, there’s somebody to counsel with, but the responsibility is much higher, and that was a big paradigm shift for me.

At one point, Rachel was with a practice which had many Mennonite and Muslim patients. She discovered transportation was a problem for some of these women, and grocery stores were not conveniently located. She came to understand that midwives can only make suggestions; they can not change client’s behavior. She also had to deal with
domestic violence and with another client, a 27 year age disparity between the client and her older male partner. All of those experiences opened her mind up to the wider world. During her intrapartum experience a supportive doctor offered to let Rachel attend the birth of one of his laboring patients. The client declined. Rachel said she learned “sometimes I can’t connect with everyone. That was an eye opener to me. She thought we were second class people. That was a very hard day for me”. From that experience Rachel says now “there are all kinds of people, and it’s a good thing that there are all kinds of providers”.

The most impressive big picture concept Rachel learned was that “every action I take doesn’t just reflect on me, it reflects on midwifery”. When the midwife leaving the practice and resigning her privileges asked Rachel to join her in the hospital where she had formerly practiced, Rachel found that her actions were scrutinized by hospital and school administrators. The school clinical coordinator explained to her

You have to follow the rules. If you don’t follow the rules you make midwifery look bad to big high up people, to all administrators. . . . And this makes midwives look bad all around. That’s when I had my eyes opened up to this is such a small community.

In addition, she and the program needed to worry about whether the hospital administration would demand that she leave the hospital. “So that was probably a good experience for me to see. Is it worth making one woman happy to ruin such a good thing?”
Carla was a mature woman when she entered her midwifery program. Often when her primary preceptor introduced her, she would say “she’s been doing labor nursing since before I was born.” And it wasn’t necessarily said in a way that said she’s got the wisdom of the ages”. Carla’s preceptor demonstrated a panoply of inconsistent and detrimental professional behaviors. Several times she had the RNs taking care of her infant while she was working with Carla on a birth. She demonstrated evasion in dealing with Carla, with the midwifery program, with the labor and delivery nursing staff, and with the consulting physician. She demonstrated suboptimal care in the interests of ostensibly avoiding a cesarean section. She demonstrated deception in how she reported her practice statistics. By Carla’s report, “she does not attend nurse midwife chapter meetings, and shows no interest in staying current on midwifery and obstetric topics”. While Carla was miserable in her placement, a younger less savvy student could have made many false assumptions about the profession and practice based on her observations of that midwife’s actions. Carla was disappointed:

She was deceptive in some ways. That bothered me. I want midwives to be what I think they ought to be. I want them all to be midwives. It was painful to realize some of them have feet of clay. It was a growing process.

When Carla was in her integration site she experienced a professionally run practice of five colleagues who were organized, and had written practice guidelines. “I appreciated that. When you got there you knew what the routine was going to be”. Carla went in to midwifery education with an eye already on the Big Picture. She was disappointed with how small the picture was while she was in the program.
Denise was able to take the skills she had already honed as a nurse who had worked for five years and translate them into how to manage as a midwifery student in both the office and especially on labor and delivery floors as a member of the team. She used those skills to deflect prejudice against students and to show what she could do to be useful. For Denise a poor clinical day occurred when she had to keep her mind’s eye focused on getting all the tasks done quickly, not necessarily well i.e.: a busy day on labor and delivery, but also needing to rush through post partum rounds. By the end of her program, Denise had learned the importance of accurately describing the scope of midwifery care to patients. She also knew the importance of collaboration with physicians,

It was more of a co-managed and collaborative feel to it. We were never taking care of a 30-weeker by ourselves, but we were taking care of them. But you know, don’t operate out of your scope of practice. If you have a question, be sure you document your backup was aware.

These big picture issues are essential elements of successful midwifery practice.

For Ann the big picture came down to nursing basics: caring and the ability to care, the human interaction. She is also aware of people, who do not hold midwives in much regard.

I was talking with our collaborating physician and got into a lunch time discussion, very innocent. It ended up in a conflict. . . . Until I was really able to spit out the data and facts and prove to him that I was knowledgeable about the
area, he kind of treated me, it wasn’t so much the student thing I don’t think, it was that I was a midwife and not a physician.

She went on to describe her initial idea of midwifery and the big picture reality of midwifery:

You think midwifery is going to be fabulous, and you’re going to catch all the babies in the world. Then you start to get into the actual politics. We’re here to provide care and education to clients, whether you do it with an MD after your name or a CNM it should be the same goal. I think that was an issue that was really eye opening.

She further described relationships with nurses and students as an exemplar of professionalism:

It teaches you how to face relationships and conflicts and things with colleagues and politics in a very professional way, which you can’t learn in a textbook, or you can’t learn in class. . . . I think unfortunately in this profession there’s a lot of cattiness and politics. I think you have to learn how to play the game, or how not to play the game and how to be honest. How to make sure you stand up for yourself, even as a student.

Phase II: De-limiting the Theory

Level III coding permitted the researcher to imagine the categories as a process. This process was further refined and is explained as the Basic Social Psychological Process (BSPP). Key factors that are seen to be integral in the process of growing into a midwife were included into the stages of the BSPP. The processes of Phase II of data
analysis included refining and synthesizing categories and labeling and describing the BSPP. There were three activities used in this phase: member checking of the results; identification of the BSPP and related concepts with the key categories, properties and interactions; and further synthesis of the results to identify core constructs of the theory.

**Member Checking**

During this phase, the participants who had previously responded to the member checks for the interview summaries were contacted again and sent a draft of Chapter 4. They were asked if they agreed with the codes and descriptions and with the emerging theory. All who responded (three out of five) had comments which supported what had been written, and did not offer any deletions. Comments written by the participants:

“I agree with this statement. EVERYTHING hinges on pleasing the preceptor!”

*(Hanging on every word and action):* “I think this is very important”. *(Having to prove yourself is stressful.):* “And there are so many parts to "prove"!” *(She knew how to teach, and she led by example.):* “This is the CRITICAL PIECE OF THE PUZZLE - a very good midwife can be a horrible teacher!” “I think you've identified some themes of significant importance.” “Great statements”. “We midwives are hard workers!”

**The Core Category: The Basic Social Psychological Process**

Schreiber, who studied with Glaser notes “the purpose of grounded theory is ‘to account for a pattern of behavior which is relevant and problematic for those involved’”. *(2001, p. 73). This is the core category, heretofore unrecognized, but which emerges through data analysis. From many accounts it seems that researchers arrive at the core category intuitively. The core category for this study is a Basic Social Psychological*
Process (BSPP). Schreiber explains that not all grounded theories will have a BSPP, because not all grounded theories reflect process. This study however, does reflect upon the process of clinical learning, and has a BSPP.

**BSPP: Growing into a Midwife**

The purpose of this study was to examine how the perceptions and meaning making of recent nurse midwife graduates affected their clinical learning while they were students. There were two research questions that were derived from the study’s purpose:

1. How do the graduates’ perceptions of the preceptor’s expressions of respect, equity and civility affect clinical learning for nurse midwife students?

2. What meaning can recent graduates make of their clinical experiences with respect to the stated, hidden, and/or null curriculum?

These questions have been answered in the data analysis and by the identification of the BSPP.

**Concepts**

Once the BSPP is identified, the focus of grounded theory data analysis is to identify related concepts. Thus the 13 Level II and seven Level III categories were analyzed further and synthesized. Five concepts have been identified that seem to have a bearing on how the students make sense of their clinical learning experiences. (n.b., the use of female pronouns occurs at this point because all participants were women.)

Everyone enters the clinical practicum with her own set of expectations for how the process is going to go and what is going to happen. These expectations are either met,
exceeded, or fall short. The student’s expectations for herself are uniformly high. Depending on the clinical site, the expectations for self can be tempered or dashed.

Vulnerability is a hallmark of being a student; this is especially noteworthy in the clinical setting. A hard word, a tone, a look can crush a student. On the other side an invitation for collegial discussion, asking for and seeming to genuinely respect the other’s opinion can diminish the sense of vulnerability and enhance self-esteem.

Getting to know each other is the key to establishing the relationship between the preceptor and the student. This basic step demonstrates respect for the student, and shows that student she will be treated as others are treated by the preceptor. Without the preceptor’s even modest attempt to know something about the student, the student remains feeling vulnerable.

Making the relationship “work” is effortless for some people, and for others will never happen. Respect, equitable relations with others, and responding civilly to others are bedrock for making the preceptor and student relationship work. In the absence of these key factors, a collegial relationship can not be established.

Awareness of all factors affecting the student role and midwifery practice happens at different times in the clinical practicum experience and at different levels. Some preceptors speak directly about big picture issues. However, many preceptors do not talk about professional issues, system issues, or pressures on the practice. Instead, the student gleans this information from observation, conversations with others, or trial and error.
Constructs

The last phase of the data analysis in Phase II was concerned with identifying constructs of the emerging theory. The first is internal to the student and involves her perceptions of what is going on as it relates to her. Simultaneously, the second construct is the development and quality of her relationship with her preceptor. The third construct, which in fact happens daily, is an awareness of how external world factors have affected the midwife student during her clinical learning. The first construct is called “defining self as a midwife”. The second construct is called “establishing a relationship with the preceptor”. The third construct is called “gaining understanding of the Big Picture” to describe the overt, hidden and null curricula. These constructs are discussed in depth in the sections on “Writing the Theory”.

“Examination of behavior from the perspective of an emergent BSPP allows the researcher to come to a new understanding of the phenomenon of study” (Schreiber, 2001, p. 76). These three emerging constructs of the emerging, substantive theory: defining self as a midwife; establishing a relationship with the preceptor; and gaining understanding of the Big Picture, illustrate how students can move through the process of clinically learning how to be a midwife by viewing what they experienced through the lens of how it affected each of them, while simultaneously attempting to establish a relationship with their preceptor (or preceptors). As the internalized doubts of self come into relationship with the preceptor, the student can also begin to bring the big picture into focus: how nurse midwifery fits into the scheme of health care, how the preceptors fit into the settings, and how the student can fit into the setting. At the end of the
program, the student is able to step up into the midwife role and step out into the profession of nurse midwifery.

These constructs reflect how the students can develop into a nurse midwife. Each student needs to step into the role to be successful in the program. This “stepping up” from the RN role to the decision making responsibilities of the midwifery role is crucial. As each of them successfully moves into this role through the program they ultimately finish the program and step out into the professional world of nurse midwifery. Table 5

Table 5

*Growing into a Midwife: Constructs, Concepts and Categories*

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Concept</th>
<th>Category (level 3 codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining Self as a Midwife</td>
<td>Self expectations</td>
<td>1. Acknowledge Me as a Person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Hanging on every word and action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Honesty and Betrayal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Marking Time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Proving Yourself</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Taking Initiative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Vulnerable</td>
</tr>
<tr>
<td>Establishing a Relationship with the Preceptor</td>
<td>Getting to know each other</td>
<td>2. Civility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Equity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Respect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Honesty and Betrayal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Preceptors take over</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Vulnerable</td>
</tr>
<tr>
<td>Gaining Understanding of the Big Picture</td>
<td>Awareness of all factors affecting the student role and midwifery practice</td>
<td>6. Learning about the big picture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Civility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Equity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Respect</td>
</tr>
</tbody>
</table>
shows the connection between the Level III codes (categories), the concepts and the constructs.

Phase III: Writing the Theory

In using grounded theory for qualitative research, the third level of data analysis becomes theoretical and requires the researcher to develop a substantive theory. Through the process of developing the theory, the researcher transitions from data analysis results to the findings of interpretation. In this chapter, the theory that has emerged from the data is briefly described in order to demonstrate the “grounding” of the theory in the data. The theory will be further explored in terms of conclusions as compared to related literature, implications and limitations in Chapter V.

Growing into a Midwife: A Theory of Graduate Nurse Midwife Students’ Process of Clinical Learning

How the students can evolve in their roles as nurse midwives depends on the relationship forged with the preceptor and others through facets of respect, equity and civility. The qualities of the preceptor-student relationship are illuminated by students’ and preceptors’ values. These values affect the recent graduates’ vision of midwifery and how the big picture of professional practice affects them. Three constructs of the theory are identified. The first construct is the internalization of the clinical learning situation as they develop into a new personal professional role. The second construct, students’ development of a relationship with their preceptors, is a concurrent development with the first construct. The students’ ability to develop an awareness of the issues affecting midwifery practice as they develop into new practicing nurse-midwives is another
construct, the big picture. These constructs do not all occur sequentially; rather, the first two constructs may develop concurrently. The third construct, while beginning to develop in the early phases of midwifery clinical development, may become much more apparent at the end of the nurse midwifery educational process.

**Construct I: Defining Self as a Midwife**

The students’ perceptions of what is going on as it relates to them encompasses feelings of vulnerability, marking time, and needing to prove themselves. Becoming a nurse midwife requires the students to come to grips with their feelings of vulnerability and defining their self-expectations. There are many facets of this construct expressed by the students. Honesty is obviously important, yet the participants gave descriptions of betrayal. Many students struggle with whether they should take initiative, and how to show initiative to their preceptors, or should they hang back and let the preceptor continue to direct their activities. The participants talked about hanging on the preceptors’ every word and action. They replayed in their minds what their preceptors had said to them, and asked did it mean what they originally thought it meant. Or did it mean something else? Further, there were times when the preceptors had to take over, but the manner in which it was done made all the difference in the students’ perceptions. The idea of marking time was a perception felt more at the end of the program. The students all had to prove themselves not just to their preceptor. Students found they had to prove themselves to the nurses and physicians they worked with as students. On a daily basis they have to prove themselves to their patients and to their families. While all students represent their programs to the world, some found a hierarchy of respect for the
various education programs. Thus, those participants had the additional burden of needing to demonstrate the worth of their own education program to the preceptor.

Construct II: Relationship: Establishing a Relationship with the Preceptor

At the same time the student was struggling with her feelings of vulnerability, needing to prove herself everywhere she went and in every encounter, and eventually with just marking time until it was all over, she also needed to establish a relationship with her preceptor. How the relationship developed for the vulnerable student and quality of her relationship with her preceptor demonstrates how respect, equity and civility are enacted. Respect flowed from whether the student felt acknowledged as a person. Respect also flowed from the honesty demonstrated in the relationship. Respect had a direct bearing on the students’ feelings of personal wellness. Finally the students commented on their observations of how respect was demonstrated with other relationships. The students perceived equity to be uniformly demonstrated. They also judged that the demonstration of equity to be personality driven. Civility was probably the least contentious value to see enacted. In professional situations, even people under great stress can usually manage to be civil. Most of the students did not have negative experiences with the preceptor taking over, and in fact upon occasion, that action was welcomed.

Construct III: Big Picture: Gaining Understanding of the Big Picture

An awareness of how external world factors have affected the midwife student and her preceptor during the clinical practicum encompasses more than what is identified in the overt curriculum, and what each of them believes the student is there to learn. Preceptors know they need to make sure the student learns safe skills and appropriate
clinical judgment. These can be critiqued and evaluated. Skills and interactions which were planned for that day’s learning, or came up through direct questioning can be watched and assessed for appropriate answers and behaviors. However, just as critical are the issues of the hidden and the null curriculum, which are enacted in every moment of the clinical learning situation. The hidden curriculum is the culture and values into which students are socialized. Learning to think as a nurse midwife and to be socialized as a midwife into the profession is the real goal of nurse midwifery clinical education. The culture and values into which students are socialized also become the null curriculum because of the neglected areas that are not taught. Perceptive students do question the null curriculum of clinical learning, but many can not see what they are being shown to not see, just as fish can not see water (Wagner, 2001).

Summary

This chapter reported the results of three phases of grounded theory analysis of nine recent graduates of five nurse midwife education programs. These participants’ perceptions of their clinical learning while enrolled in their programs formed the basis of the data. The data analysis was explained, and member checking was described. Through data analysis, seven categories and 14 subcategories were identified. Supporting quotations were provided. The emergence of the basic social psychological process, “Growing into a Midwife”, was explained. Five related concepts were identified:

Self expectations; Vulnerability; Getting to know each other; Making the relationship “work”; and Awareness of all factors affecting the student role and midwifery practice. Three constructs, Defining Self as a Midwife, Establishing a
Relationship with the Preceptor, and Gaining Understanding of the Big Picture were identified. The research questions were answered. A theory of the graduate nurse midwife’s process of clinical learning was proposed. The theory describes the students’ internalized thoughts and feelings they experienced as they become a midwife while simultaneously working to establish relationships with their preceptors and others and coming to understanding the big picture of the clinical setting.
CHAPTER V
DISCUSSION

Introduction

Grounded theory methods of qualitative research were used to understand the experiences of nine recent graduates of five nurse midwife education programs. These participants’ perceptions of their clinical learning while enrolled in their programs formed the basis of the data. Results of the inductive data analysis process – categories, concepts and constructs - were used to answer the research questions, identify the Basic Social Psychological Process “Growing into a Midwife” and develop a descriptive theory “Growing into a midwife: A theory of graduate nurse midwife students’ process of clinical learning”. The substantive theory provides insights into features of midwifery socialization. These insights encompass students’ thoughts and feelings they experienced as they become a midwife while simultaneously working to establish relationships with their preceptors and others and coming to understanding the big picture of the clinical setting. This chapter will include interpretation, conclusions, implications for nurse midwifery education, limitations and recommendations for further study.

Interpretation of Growing into a Midwife:

A Theory of Graduate Nurse Midwife Students’ Process of Clinical Learning

The following research questions guided the investigation of this study:

1. How do the graduates’ perceptions of the preceptor’s expressions of respect, equity and civility influence clinical learning for nurse midwife students?
2. What meaning can recent graduates make of their clinical experiences with respect to the stated, hidden, and/or null curriculum?

How the students evolve in their roles as nurse midwives depends on the relationship forged with the preceptor and others through facets of respect, equity and civility. The qualities of the preceptor-student relationship are illuminated by students’ and preceptors’ values. These affect the recent graduates’ vision of midwifery and how the big picture of professional practice affects them. Three constructs of the theory that developed are identified. The first construct is the internalization of the clinical learning situation as they develop into a new personal professional role. The second construct, students’ development of a relationship with their preceptors, is a concurrent development with the first construct. The student’s ability to develop an awareness of the issues affecting nurse midwifery practice as she develops into a new practicing nurse midwife is another construct, the big picture. In the context of this study, these constructs do not all occur sequentially; rather, the first two constructs may develop concurrently. The third construct, while beginning to develop in the early phases of midwifery clinical development, may become more apparent at the end of the nurse midwifery educational process.

The issues of respect, equity, and civility hidden from view in the overt curriculum, are highly influential throughout the students’ development as midwives. In other studies (Clark, 2008), students’ perceptions of and feelings about faculty incivility have demonstrated serious and long term consequences. For example, some students reported they relived the faculty member’s incivility on a daily basis and even cried about
it years later (Clark, 2008). Incivility did not emerge as an issue for this study’s participants. However, the issues of respect and equity did emerge as important issues in the clinical setting and had influence on students’ feelings about their clinical learning experiences.

One of several theories that informed the current study’s findings is oppressed group theory. Other nursing researchers have written about the importance of recognizing the actions of oppressed groups in midwifery and midwifery education, also (Begley, 2002; Hunter, Diegmann, Dyer, Mettler, Ulrich, & Agan, 2007; Roberts, 1996). Freire (1970) posited oppressed groups have acclimated to domination by the oppressor group, and come to regard their position as inherently inferior. The nurse midwife profession, and many individual CNMs, unfortunately, have many of the characteristics of a group oppressed by the dominant culture, which in this case is the medical establishment. Medical education and knowledge are viewed as superior by society as a whole and by physicians, nurses and advanced practice nurses among many other professions. Drawing on Roberts (1983, 1996) research and theorizing, nursing education has been controlled and influenced by the medical establishment since the early Twentieth Century and limits its curricula to support the values of the dominant culture. This capitulation of nursing knowledge to the medical establishment works to suppress conflict between the dominant and marginalized groups (Roberts, 1983). Nurse midwifery education in the United States began in the 1920s with only physicians as teachers. By the 1960s physicians as teachers of nurse midwifery education had waned, and currently there are proscriptions against physicians playing a large role in nurse midwifery education. The model for midwifery
education is The Core Competencies for Basic Midwifery Practice (Appendix B). The Core Competencies open with Hallmarks of Midwifery that include caring, nurturing and other nursing characteristics. However the preponderance of the Core Competencies is on diagnosis of problems, management, and systematic development of data to develop a plan of care, based on anatomy and physiology, pharmacokinetics and other scientific principles all of which together form the core of the medical model of care. The medical model of care is not based on assumptions of normalcy and support of natural processes. The medical model of care is a curative model, assuming something is wrong with the body and it must be “fixed”, and is based on interventions to effect improvement.

In addition to the medical model becoming the normative domination of the education process, the majority of nurse midwives, and all the nurse midwives in this study, find themselves working in hospital settings. Hospitals were established for doctors to work in. In the hospital, midwives clearly hold a minority position without power and lack of control of the work environment. Roberts (1996) theorizes that nurse practitioners (of which nurse midwives form one group) are a marginal group. A marginal group is rewarded for looking (wearing lab coats), thinking (using the medical model as the basis for care), and acting (seeing a new patient every 15 minutes, or writing prescriptions) like doctors, but they will receive only limited rewards, and never the full control and autonomy of practice that the medical profession has (Roberts, 1996, 2006).

Nurse midwives exhibit other characteristics of oppressed groups in some situations: “lack of self-esteem, horizontal violence, intergroup rivalry, inward aggression” (Roberts, 2006, p. 26.). All of these characteristics were identified by
participants in this study. Outsiders are struck by the negative messages nurses send to
one another, and as the interviews in this project demonstrate, nurse midwives are no
different. Nurse midwives demonstrate ineffective communication, passive
aggressiveness as well as silencing, just as nurses do. Interestingly, because silencing for
some nurses extends across their lives (both personally and professionally) the need to
avoid conflict and maintain the status quo in the workplace, may be a learned behavior,
perhaps embedded through socialization as women. As demonstrated by descriptions of
several preceptors’ behaviors, avoiding and compromising are common conflict
management strategies nurses use. Several preceptors identified by this study’s
participants demonstrated these behaviors e.g.: the students’ reporting how preceptors
talked about others when they were not present. The avoiding and compromising
behaviors discourage both dissent and positive expressions about nursing and midwifery
(Roberts, 2006).

Another of the theories that informed the current study’s findings is feminism. In
feminist thought, women are central in all considerations and analysis (Huntington,
2002). While keeping women central, feminism is concerned with equity for both
women and men. This equity comes through working on restructuring societal roles and
relationships to create equal rights and power for both women and men (Hartrick, 1998).
Huntington and Gilmour (2001) observe that the concerns about power have been at the
very heart of feminist thinking for many years. Huntington and Gilmour (2001) clarify
that feminist thought acknowledges the shifting nature of power and further
acknowledges that the concept of power is expansive, rather than being an oppressive force that requires a victim.

As empowering for both genders as feminism is, feminist theory has not been widely embraced by nursing, as demonstrated by nursing’s minority position in the health care field, although nurses are the largest segment of employed women professionals in health care. However, feminist theory encompassing liberal feminism, Marxist, socialist and radical feminism actually strongly influences the profession of nurse midwifery. Unfortunately though, many nurse midwives do not view themselves as feminist, even though their actions show otherwise.

Most especially liberal feminist views of unequal opportunities for men and women are at the heart of nurse-midwives’ struggles for their hospital-admitting privileges and third-party reimbursement. In working and lobbying for mothers, children, and the poor, nurse-midwives are pushing for the same goals embodied in Marxist and socialist feminist thought. The woman-centered view of radical feminism is exactly what nurse-midwives are calling for when they promote each birthing woman’s perception and control of her own birth (McCool & McCool, 1989, p. 326).

All of these viewpoints of feminism, as McCool and McCool demonstrate, bear upon nurse midwifery practice and education. The researcher for this study finds it difficult to locate this study in a particular segment of feminist thought as all the perspectives work to keep women central to the questions at hand, and to reform customary power relations (Hezekiah, 1993).
Nursing’s reluctance to embrace feminism, and the indifference of many nurse midwives to feminist thought, causes friction with many of the incoming generation of nurse midwife students. Many nurse midwife students come from women’s studies, feminist and social justice backgrounds, where they have developed particular empathy for gender and power issues. In this study, the women who entered nurse midwifery as a second career were the most critical of their preceptors’ callous behaviors. One of them became physically ill at the thought of going to another clinical day. All students were at their clinical sites to learn woman-centered care. Many nurse midwifery students did learn this type of feminist care, care that values women and goes further by confronting “systematic injustices based upon gender” (Chinn & Wheeler, 1985, p. 76), under the tutelage of older skilled midwives. The students observed that these women were less influenced by the environment imposed by the medical establishment because they were able to practice independently. These women were also more skilled at manipulating the environment to meet women’s needs than other midwives.

Work on critical pedagogy also supports the current study’s findings. In curriculum studies, one line of thought, the examination and conceptualization of critical pedagogy, has led to analyzing the assumptions of power and hegemony in the educative process, working toward emancipatory education. The assumptions of who holds the power in the work place and the classroom, and who holds the power in establishing, developing and disseminating curriculum are significant considerations having enormous impact on students’ clinical learning. This theory of becoming a midwife which has emerged from this study is grounded in understandings of hegemony and power as they
relate to the clinical education process of nurses becoming nurse midwives. Harden (1994) locates critical pedagogy in “hope, liberation and equality, with agency and raised consciousness at centre stage, albeit with structural constraints acknowledged” (p. 32). Harden affirms that teaching is a political activity which is value-laden and biased. Therefore it is extremely important for nurse midwives to acknowledge their position in the medical area and to teach and work for change. Emancipatory education has a powerful agenda: negative critique, counter hegemonic practices and conscientisation (leaning to perceive social, political and economic contradictions and conceiving of ways to take action against oppressive contradiction (Harden, 1994, p. 35)). Nurse midwifery preceptors can seek to effect change through clinical teaching as well as working as nurse midwives. This is demonstrated by preceptors who are able to show students how to foster awareness and appraise conditions meriting change. They worked mutually with the students to develop the facility to change the conditions that shape unequal social relations for both the patients they cared for the students (Lynam, 2009).

It is possible to overcome the sense of powerlessness, not through horizontal violence (preceptor to student: “don’t ever talk to a doctor again”), but through supportive team work (Zeidenstein, 2000). The stress of being marginal can be intense, resulting in self-doubt, sacrifice of professional and personal dignity, and loss of inner strength. The alternative way to address the problem marginalization for nurse midwives involves “embracing the midwifery model of care, knowing that midwives’ uniqueness is their greatest strength, and commit to the philosophy that women and their families come first” (Zeidenstein, 2000, p.86). Kennedy (2001) writes about “The Art of doing
‘Nothing’ well”. This means that when utilizing processes that support normalcy, the nurse midwife intervenes only when necessary. This practice is the embodiment of the midwifery model of care, but it starkly contrasts with the medical model, based as it is on a curative model of care which proceeds from the assumption that there is something wrong in the body that must be fixed. When practicing CNMs enact their midwifery beliefs, the new nurse midwives can emulate their nurse midwife preceptors instead of wasting energy trying to figure out how to game the system; and, in turn, make their enthusiasm contagious (Zeidenstein). Through uplifting enthusiasm, both preceptor and student will experience growth and each become richer in spirit.

This formula will require a conscientious effort to acknowledge in the overt curriculum the benefits, not just to the clients of woman-centered midwifery model of care, but the huge benefits to the preceptors (the practicing clinicians) and the students. However, doing so is going to involve much reflective hard work by nurse midwifery programs and preceptors. Lange and Kennedy (2006) suggest that there is a theory-practice gap between what the students learn in the classroom and what they practice in the clinical setting, especially as it relates to the process of care supporting normal birth. Jordan and Farley (2008) reported that students have demonstrated agreement with two Core Competency Hallmarks: therapeutic value of human presence and non-intervention in the absence of complications. Students did describe positive preceptor behaviors for both hallmarks, although there were stronger scores for the therapeutic presence. Both of these studies in congruence with the current study suggest the importance of preceptors being able to discuss with students their philosophy of midwifery care, and the thought
processes involved in their decision making. Especially in teaching hospitals, where the medical model is so strong, and providers are pressured to conform to that model, the preceptors need to explain “their beliefs in their own decision-making and resolve for persevering in challenging circumstances” (Jordan & Farley, p. 418).

Conclusions

In conclusion, aspects of the current study are informed by specific theorizing in the areas of oppressed group theory, feminism, and critical pedagogy. Many curricular issues in current nurse midwifery education have subtly shifted over the years from the overt into the hidden curriculum, or even completely removed, and thus can be identified as part of the null curriculum in nurse midwifery education. Reasons for this shift are caused by the need to include new skills and technologies, so that now there “isn’t room” (in the curriculum), or “that isn’t midwifery”. For instance, because of the emphasis on understanding the medical model of care in obstetric and gynecologic care, genuine discussions of ethical enactment in the clinical setting may not be discussed in the classroom or the clinical settings. More emphasis is possibly placed on understanding medical facts and treatments of conditions than may be placed on the support and nurturing of the family through the pregnancy, and very little thought may be given to curriculum enactment of feminism, critical pedagogy, or the countering of oppressed group actions.

In a busy out-patient or in-patient setting, the enactment of respect and equity sometime fall prey to stress. Nevertheless, it remains important for nurse midwifery programs and CNM providers to stress to students the importance of woman-centered
care. Using the midwifery model of care, which encompasses woman-centered, individualized care within the boundaries of safety will enact respect for all, treat everyone equitably and keep relationships civil. In this study, this enactment of respect was more admirably demonstrated by younger CNM preceptors and by CNM preceptors in more independent practices. Nurse midwives who practice in busy teaching centers, where life is more stressful, demonstrated oppressed group behaviors. For instance students observed their preceptors yelling at women in labor to calm down, an obvious demonstration of oppressed group behavior.

Students enter the clinical preceptors’ arena in a vulnerable state, filled with hopes and fears, and glowing with how they want to practice as nurse midwives. They then encounter the reality of the clinical setting, hoping to find connection with their preceptors and become the nurse midwife of their dreams. Most are able to accomplish this transition and grow in the process. Some, however, are sorely tested by the experience. This study did not follow the recent graduates to see if they attained a first nurse midwifery job and how long they stayed in it. But at least one participant is known to the researcher to have never worked as a nurse midwife, in part because of her devastated self-esteem by the end of the program.

Implications for Nurse Midwifery Education

As Dewey wrote in 1938, education should not be preparation for a future democratic way of life, but rather education should embody the enacted experience of democratic living. His argument is based on his pragmatic insights into the positive, generative, and enduring consequences of here-and-now democratic transactions. The
purpose of undertaking this research project was to examine how the experience of
democratic educational processes in nurse midwifery clinical education is enacted. The
implications for nurse midwifery education are enormous. In addition to basic preceptor
preparation, preceptors need to be better ethically and morally prepared to teach students.

One of the underlying issues that was explored by this investigation was what
happens when students, who are registered nurses first – people with their own
credentials – are put into busy sites with volunteer preceptors who do not have formal
training in education? What happens in a situation when both the student and the
preceptor are unsupported because the site and/or the preceptors are unprepared?
Whether the onus of responsibility for the basic preceptor preparation falls to the nurse
midwifery programs, to the individual CNM preceptors or to the practices recruited as
clinical sites, does not matter. The fact is that many preceptors, as identified by the
participants of this study, are inadequately prepared to assume the preceptor role.

The ACNM Accreditation Commission for Midwifery Education, because of its
limited role, mandates only that all the teachers document some “teacher preparation”.
There is no evaluation of how effective the teacher preparation is. Site visits are advised,
but not mandated. One of the students reported multiple site visits (without any change in
practices by the preceptor), but two of the programs do not do any site visits by the
students’ reports. There is another directive that midwifery teachers work as a midwife
for one year prior to beginning any midwifery teaching. This directive was in place long
before Patricia Benner’s (1984) ground breaking work was done on the development of
nurses from novice to expert in their professional role. As Lange and Kennedy (2006),
Jordan and Farley (2008), and this study show, many of the clinical experiences are taking place in high volume medical teaching centers, not in the low volume patient-centered care areas of the 1980’s. In the current health care environment, where the volume and complexity of psychosocial and health problems at practice sites is increasing, it is much harder for a newer practitioner to feel confident in her skills at the end of a year than two decades ago. Therefore, programs should not encourage newer practitioners, or any practitioner who is not confident in her skills, to be preceptors. Nurse midwife programs, just as other APN specialties and other health professional programs such as Physician Assistants are desperate for clinical sites and preceptors (Danielsen, 2008). However, being desperate does not mean that nurse midwifery programs should grasp on to any practitioner as a preceptor.

Two nurse midwifery educators, Dr. Claire Andrews, CNM, FAAN and Dr. Patricia Burkhardt, CNM, FACNM, confirm that lack of awareness and practical understanding on how to enact the Code of Ethics during clinical learning is a null curriculum problem for a beleaguered profession that puts all of its energy into survival (personal communication March 4, 2010). Nurse midwifery educators should do more than merely give lip service to the Code of Ethics. Concepts of hidden and null curriculum inform clinical learning. Respect, equity and civility have a huge influence on a learner’s anxiety level (Cook, 2005). Research documents that people in a higher state of anxiety have difficulty learning. Enacting respect, equity and civility towards the student may help to allay anxiety. Respect, equity and civility are important, and they are not as carefully addressed at the experiential level as they could be. Nurse midwifery
programs need to examine their curriculum to see how they express respect, equity and
civility in classroom conversations, lectures, simulations, and all other teaching methods.
Having done that, the programs need to show the CNM preceptors in course materials they give them that outline program expectations, evaluation materials the CNMs use with students, and through program site visits, among other tools, how the program expects their students to be influenced by these key curricular issues.

Since its inception, nurse midwifery education has been heavily influenced by the medical model of care. Now is an appropriate time for program directors and The ACNM Accreditation Commission for Midwifery Education, to evaluate what the core principles of midwifery education ought to be, and how they should be conveyed to students in both classroom/online and clinical learning. This is going to be a long and painful task, but there is a growing body of evidence to support that all stakeholders – students, faculty, preceptors – are fairly unsatisfied with the way things are at the present time. If nurse midwifery educators believe that the Hallmarks of Midwifery (Appendix B) are important enough to be Hallmarks of Core Competency for Basic Midwifery Practice, then programs should address them in the overt curriculum, not allow them to be implied in the hidden curriculum, or ignored in the null curriculum.

Limitations

Methodological Limitations

This study has presented students’ experiences in the clinical setting with their preceptors as described in retrospect by recent graduates of nurse midwife programs. In presenting findings both methodological and theoretical problems must be acknowledged.
Both quantitative and qualitative methods have methodological flaws. Grounded theory methods were appropriate for this subject of interest, as very little to nothing was known about the topic prior to beginning the investigation. However, because of the limited number of nurse midwifery programs that were used by design, the results have limited transferability. While the participants represented five of 37 total nurse midwifery education programs in the United States, just 33 programs are classroom based (not completely distance education), and an additional three programs have faculty practices and so did not meet the inclusion criteria. Thus the participants actually represented five of 30 nurse midwifery education programs eligible for this study. However, the geographical representation was limited by not encompassing any programs in New England, the southern or western United States. In addition, the general ethnic diversity of the participants was limited. This was a more homogenous group of participants than the researcher had anticipated interviewing. Although theoretical sampling was used in an attempt to provide data that adequately described the students’ perceptions in question, the small number of participants limited to some degree how this was achieved.

Participant recruitment presented larger problems than anticipated. Ultimately the researcher had to rely on how well the program director presented the project to the recent graduates for the initial contacts. Recent graduates who had particular interests they were eager to share were more likely to volunteer.

Only the perspectives of the students were sought. However, the student preceptor relationship is dynamic and the preceptors’ perspectives possibly differ from the students’. The background and ethnic heritage of the preceptors is unknown to the
researcher, because the researcher deliberately refrained from asking about it unless the participants volunteered the information.

Other methodological restrictions are concerned with the limited size of the volume of data. Each participant was interviewed only once, after completion of the program. A deeper level of theoretical saturation might have been obtained had the researcher been able to conduct a follow up interview, had a larger, more diverse number of participants, and been able to incorporate any data from journals the participants kept of their clinical time. In addition, the researcher found following the steps for grounded theory data analysis taxing, and difficult to work with, and ultimately did not follow the steps precisely.

Theoretical Limitations

Reasons for theoretical limitations to transferability of findings of this study are associated with the use of the grounded theory approach to qualitative research. This study is the beginning; it can not present an ultimately well crafted formal theory due to the limitations of the sample size and the skills of the novice researcher. Grounded theorists, as suggested by Glaser and Strauss (1967), search for and then seek to understand and predict social processes present in interactions between people. In the case of this study, the human interaction was how the students evolve in their roles as midwives and the relationship they forged with the preceptors and others through facets of respect, equity and civility. The basic social psychological process was “Growing into a Midwife”. Out of grounded theory two types of theory may emerge: formal and substantive. Substantive theories are generated only for a particular, limited, and
observed area of inquiry. Substantive theory may be used to generate formal theory. Therefore substantive theories, such as the one that emerged from the data of this study, will have specific relevance for only the participants of this study. However, procedures were used during data collection and analysis to promote rigor of the findings and make possible the transferability to other settings.

Directions for Future Research

There are multiple areas for clarification through future research. The first area would be to replicate the study with a larger group of participants using similar selection criteria, but from different geographic areas.

Another fruitful study would be with graduates of programs that have a faculty practice. The assumption with a faculty practice is that the preceptors are dedicated to teaching, have reflected on their teaching practices and that their teaching is part of their paid employment, not a voluntary added on activity. This study focused on preceptors who do not receive an honorarium for their teaching efforts. What is the experience like for students who have preceptors who are paid an honorarium compared with students who have preceptors who do not receive monetary compensation?

Another interesting study would be with graduates of distance education programs. There are several completely distance nurse midwifery education programs in the United States now. One, CNEP, has been teaching students since 1993, others are much more recent. The assumption with distance programs is that the preceptors would not receive as much program support as from a locally run program.
When we find some preceptors who are less than optimal, are they uniformly like that with every student, or do they have particular students that they treat badly, the way an abusive family picks on only one child? What happened to the others that prevents them from acting out? Would coaching improve the preceptors’ behaviors and precepting skills?

Are there transferable skill sets for preceptors? It seems important to identify those skills which preceptors who have been identified as good or great have. Those skills could be modeled for students who will become preceptors, as well as for others who are or will become preceptors.

This study was not intended as a critique of nurse midwife preceptors. However, an interesting study would be to interview preceptors about their implementation of the Hallmarks of Midwifery and of the midwifery management process. An especially interesting line to follow would be how they try to teach those concepts while socializing midwifery students into their new role.

This study had students who had a variety of preceptors, some who had been practicing for over 30 years, and some who had recently begun to practice. The majority of preceptors were described as good, even nurturing and caring. Many preceptors were described as understanding how the students learned, and setting up experiences for them based on their learning needs. A preceptor can not bring out something in a student that is not there, but she can help develop the gifts, characteristics and skills that the student comes with to become a better midwife. Some of the research questions that could be developed are: How do good preceptors get so good? What are good preceptor’s
preceptors like? Is there anything about how the good preceptors were precepted that transferred to how they precept students themselves?

An interesting area for research would be to explore whether there are differences in preceptor attitudes in different geographic areas. This study did not interview students from New England programs, from southern programs, or from western United States programs. Many of the participants were from programs that used preceptors in very busy teaching centers in urban settings where allowances for extra time to teach were not made. In several of the sites, the CNMs reluctantly (by the graduates’ accounts) found themselves being preceptors, as those were the days the students came in for their clinical practicum. Does this pattern extend across the country in large urban practices? Are there practices all over the country where students take “pot luck” for their preceptor of the day?

While the majority of preceptors are able to respond to the students as adult learners, there is a significant population of preceptors that have difficulty with the issues of respect and civility in their treatment of their nurse midwife students. An area for future research can encompass how to encourage those preceptors to recognize their behaviors and adjust them to the situation with the specific student.

Another particularly interesting project would be to collect data through observations and interviews with core program faculty. The interviews would be to uncover what the general themes, issues and topics are that the programs have assigned to the hidden and to the null curriculum. The data could also help to uncover if the decisions had been deliberate or accidental. That line of study would help answer questions such
as: Why is the Code of Ethics not a key focus for curriculum conversations? What is preventing the necessary dialogical engagement that will result in proactive curriculum problem solving? What are the embedded structural reasons for this lack of curriculum interest?

The participants for this study were limited in diversity because they were all Caucasian women. What are the experiences of diverse students with preceptors? This study did not explore diversity of the preceptors. Students reported single cases of working one day with a man or a midwife from the Caribbean. An interesting study would be to investigate the attitudes and perceptions of a diverse group of CNM preceptors and their attitudes about respect and equity and civility.

Summary

This study described the descriptive theory “Growing into a midwife: A theory of graduate nurse midwife students’ process of clinical learning”. The theory describes the students’ internalized thoughts and feelings they experienced as they become a midwife while simultaneously working to establish relationships with their preceptors and others and coming to understanding the big picture of the clinical setting. This chapter included interpretation of the theory using oppressed group, feminist, and critical theories, conclusions of the study and the interpretation, implications for nurse midwifery education, methodological and theoretical limitations of the study are described and recommendations for further study.
APPENDIXES
APPENDIX A

American College Of Nurse-Midwives

Code Of Ethics
Certified nurse-midwives (CNMs) and certified midwives (CMs) have three ethical mandates in achieving the mission of midwifery to promote the health and well-being of women and newborns within their families and communities. The first mandate is directed toward the individual women and their families for whom the midwives provide care, the second mandate is to a broader audience for the “public good” for the benefit of all women and their families, and the third mandate is to the profession of midwifery to assure its integrity and in turn its ability to fulfill the mission of midwifery.

Midwives in all aspects of professional relationships will:
1. Respect basic human rights and the dignity of all persons.
2. Respect their own self worth, dignity and professional integrity.

Midwives in all aspects of their professional practice will:
3. Develop a partnership with the woman, in which each shares relevant information that leads to informed decision-making, consent to an evolving plan of care, and acceptance of responsibility for the outcome of their choices.
4. Act without discrimination based on factors such as age, gender, race, ethnicity, religion, lifestyle, sexual orientation, socioeconomic status, disability, or nature of the health problem.
5. Provide an environment where privacy is protected and in which all pertinent information is shared without bias, coercion, or deception.
6. Maintain confidentiality except where disclosure is mandated by law.
7. Maintain the necessary knowledge, skills and behaviors needed for competence.
8. Protect women, their families, and colleagues from harmful, unethical, and incompetent practices by taking appropriate action that may include reporting as mandated by law.

Midwives as members of a profession will:
9. Promote, advocate for, and strive to protect the rights, health, and well-being of women, families and communities.
10. Promote just distribution of resources and equity in access to quality health services.
11. Promote and support the education of midwifery students and peers, standards of practice, research and policies that enhance the health of women, families and communities.

Source: Ad Hoc Committee on Code of Ethics  Approved by Board of Directors June 2005
APPENDIX B

American College Of Nurse-Midwives

Core Competencies For Basic Midwifery Practice
Core Competencies for Basic Midwifery Practice
The core competencies for basic midwifery practice describe the fundamental knowledge, skills, and behaviors expected of a new practitioner. Accordingly, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy-makers and constitute the basic requisites for graduates of all nurse midwifery and midwifery education programs accredited/preaccredited by The American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA)*.

Midwifery practice is based on the Core Competencies for Basic Midwifery Practice, The Standards for the Practice of Midwifery and the Code of Ethics promulgated by the American College of Nurse-Midwives. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by ACNM or the American Midwifery Certification Board, Inc. (AMCB), formerly the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary health care providers.

The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives may choose to expand their practice following the guidelines outlined in Standard VIII of the Standards for the Practice of Midwifery.

Midwifery education is based on an understanding of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. Midwives provide health care that incorporates appropriate medical consultation, collaborative management, or referral. Each education program is encouraged to develop its own method of addressing health care issues beyond the scope of the current core competencies, and each graduate is responsible for complying with the laws of the jurisdiction where midwifery is practiced and ACNM Standards for the Practice of Midwifery.

ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report (1996)*, the ACNM philosophy (2004), and ACNM Board of Directors' Position Statement on Certified Nurse-Midwives and Certified Midwives as Primary Health Care Providers/Case Managers (1997). Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. As primary health care providers, CNMs and CMs assume responsibility for the provision of, and referral for, appropriate health care services that are within a defined scope of practice. The concepts, skills, and midwifery management process identified below comprise the foundation upon which practice guidelines and educational curricula are built. The core competencies are reviewed and revised regularly to incorporate changing trends in midwifery practice. This document must be adhered to in its entirety.
I. Hallmarks of Midwifery
The art and science of midwifery are characterized by these hallmarks:
A. Recognition of pregnancy, birth, and menopause as normal physiologic and
developmental processes
B. Advocacy of non-intervention in the absence of complications
C. Incorporation of scientific evidence into clinical practice
D. Promotion of family-centered care
E. Empowerment of women as partners in health care
F. Facilitation of healthy family and interpersonal relationships
G. Promotion of continuity of care
H. Health promotion, disease prevention, and health education
I. Promotion of a public health care perspective
J. Care to vulnerable populations
K. Advocacy for informed choice, shared decision-making, and the right to self-
determination
L. Cultural competence
M. Familiarity with common complementary and alternative therapies
N. Skillful communication, guidance, and counseling
O. Therapeutic value of human presence
P. Collaboration with other members of the health care team

II. Components of Midwifery Care: Professional Responsibilities of CNMs
and CMs
The professional responsibilities of CNMs and CMs include, but are not limited
to, these components:
A. Promotion of the hallmarks of midwifery
B. Knowledge of the history of midwifery
C. Knowledge of the legal basis for practice
D. Knowledge of national and international issues and trends in women's health and
maternal/newborn care
E. Support of legislation and initiatives which promote high quality health care services
F. Knowledge of issues and trends in health care policy and systems
G. Commitment to the ACNM's Philosophy, Standards, and Code of Ethics
H. Ability to evaluate, apply, interpret, and collaborate in research
I. Participation in self-evaluation, peer review, continuing education, and other activities
that ensure and validate quality practice
J. Development of leadership skills
K. Familiarity with practice management and finances

III. Components of Midwifery Care: Midwifery Management Process
The midwifery management process includes:
A. Systematically compiling and updating a complete and relevant database for the
comprehensive assessment of each client's health, including a thorough health history
and physical examination
B. Identifying problems and formulating diagnoses based upon interpretation of the
database
C. Identifying health care needs/problems in collaboration with the client
D. Providing information and support to enable clients to make informed decisions and to
assume primary responsibility for their own health
E. Developing a comprehensive plan of care with the client
F. Assuming primary responsibility for the implementation of individualized plans
G. Obtaining consultation, planning, and implementing collaborative management; referral or transferring the care of the client as appropriate
H. Initiating management of specific complications, emergencies, and deviations from normal
I. Evaluating, with the client, the effectiveness of care and modifying the plan of care as appropriate.

IV. Components of Midwifery Care: Fundamentals
A. Anatomy and physiology, including fetal anatomy and physiology
B. Normal growth and development
C. Clinical genetics
D. Psychosocial, sexual and behavioral development
E. Basic epidemiology
F. Nutrition
G. Pharmacokinetics and pharmacotherapeutics
H. Principles of individual and group health education

V. Components of Midwifery Care: The Primary Health Care of Women
A. Health Promotion and Disease Prevention
Independently manages primary health screening and health promotion of women from the perimenarcheal through the postmenopausal periods

MIDWIFERY PRACTICE
1. Applies knowledge of midwifery practice that includes, but is not limited to, the following:
   a. Nationally defined goals and objectives for health promotion and disease prevention
   b. Parameters for assessment of physical and mental health, including domestic violence, sexually transmitted infections, and substance, alcohol, and tobacco use
   c. Nationally defined screening recommendations to promote health and detect/prevent disease
   d. Management strategies and therapeutics to facilitate health and promote healthy behaviors
2. Applies knowledge of midwifery practice in the preconception period that includes, but is not limited to, the following:
   a. Assessment of individual and family readiness for pregnancy, including emotional, psychosocial, and sexual factors
   b. Impact of health, family and genetic history on pregnancy outcomes
   c. Influence of environmental and occupational factors, health habits, and behavior on pregnancy planning
   d. Health and laboratory screening to evaluate the potential for a healthy pregnancy
3. Applies knowledge of midwifery practice of gynecologic care that includes, but is not limited to, the following:
   a. Human sexuality
   b. Common screening and diagnostic tests
   c. Parameters for differential diagnosis of common gynecologic problems, including sexually transmitted infections
   d. Essentials of barrier, hormonal, mechanical, chemical, physiologic, and surgical conception control methods
e. Management strategies and therapeutics for common gynecologic problems and family planning needs
f. Management strategies and therapeutics for sexually transmitted infections that includes indicated partner evaluation, treatment, or referral
g. Counseling principles for sexual behaviors that promote health and prevent disease
h. Counseling, clinical interventions and/or referral for unplanned or undesired pregnancies, sexual concerns, infertility, and common gynecologic problems.

4. Applies knowledge of midwifery practice in the perimenopausal, postmenopausal and aging periods that includes, but is not limited to, the following:
   a. Effects of menopause on physical and mental health
   b. Identification of deviations from normal
   c. Counseling and education for health maintenance and health promotion in the aging woman
   d. Management strategies and therapeutics for alleviating the common discomforts that may accompany the perimenopausal period

B. Management of Common Health Problems

Independently manages, within the CNM's/CM's defined scope of practice, common health problems of women, utilizing consultation, collaboration, and/or referral to appropriate levels of health care services as indicated

1. Applies the knowledge of midwifery practice that includes, but is not limited to, the following:
   a. Identification of deviations in the following areas:
      Cardiovascular/hematologic
      Dermatologic
      Endocrine
      Eye, ear, nose, and throat
      Gastrointestinal
      Mental health
      Musculoskeletal
      Neurologic
      Respiratory
      Renal
   b. Management strategies and therapeutics for the treatment of common health problems/deviations of essentially healthy women

VI Components of Midwifery Care: The Childbearing Family

A. Care of the Childbearing Woman: Independently manages the care of women during pregnancy, childbirth, and the postpartum period

1. Applies knowledge of midwifery practice in the antepartum period that includes, but is not limited to, the following:
   a. Diagnosis of pregnancy
   b. Genetics, placental physiology, embryology, and fetal development
   c. Epidemiology of maternal and perinatal morbidity and mortality
   d. Influence of environmental and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
   e. Emotional and psychosexual changes during pregnancy
f. Health risks, including but not limited to, domestic violence, sexually transmitted infections, substance, alcohol, and tobacco use

g. Promotion of breastfeeding

h. Indicators of normal pregnancy and deviations from normal

i. Assessment of the progress of pregnancy and fetal well-being

j. Etiology and management of common discomforts of pregnancy

k. Management strategies and therapeutics that facilitate healthy pregnancy and outcome

l. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation

2. Applies knowledge of midwifery practice in the intrapartum period that includes, but is not limited to, the following:

a. Diagnosis and assessment of labor and its progress

b. Assessment of maternal and fetal status during labor

c. Indicators of deviations from normal, including complications and emergencies

d. Measures to support psychosocial needs during labor and delivery

e. Management strategies and therapeutics to facilitate normal labor progress

f. Techniques for (i) administration of local anesthesia, (ii) spontaneous vaginal delivery, (iii) third stage management, and (iv) performance and repair of episiotomy and repair of lacerations.

g. Techniques for management of emergency complications and abnormal intrapartum events

3. Applies knowledge of midwifery practice in the postpartum period that includes, but is not limited to, the following:

a. Postpartum self-care, newborn care and feeding, contraception, and family relationships

b. Management strategies and therapeutic to facilitate a healthy puerperium

c. Facilitation of the initiation and establishment of lactation

d. Deviations from normal and appropriate interventions including management of complications and emergencies

e. Management of discomforts of the puerperium

B. Newborn Care: Independently manages the care of the newborn during the first 28 days of life.

1. Applies knowledge of midwifery practice that includes, but is not limited to, the following:

a. Effect of maternal fetal risk factors on the newborn

b. Bonding and attachment theory

c. Evaluation of the newborn: physical and behavioral assessment and gestational age assessment

d. Primary health screening and health promotion up to 28 days of life

e. Methods to facilitate adaptation to extrauterine life: (i) stabilization at birth, (ii) resuscitation, and (iii) emergency management

f. Facilitation of continuation of breastfeeding

g. Indications of deviation from normal and appropriate interventions

h. Management strategies to facilitate integration of the newborn into the family

Source: Education Section, Division of Education
Approved by the ACNM Board of Directors: May 31, 2002
(Supersedes ACNM Core Competencies for Basic Midwifery Practice, May 1997)

Language in the introduction only was revised and approved by the ACNM Board of Directors in June 2004. This language reflects the retiring of the Guidelines for the Incorporation of New Procedures into Nurse-Midwifery Practice in 2003, concurrent with the revision of the ACNM Standards for Midwifery Practice.
APPENDIX C

Kent State University

Institutional Review Board Approval
KENT STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD
APPLICATION FOR APPROVAL TO USE HUMAN RESEARCH PARTICIPANTS

Send completed forms to one of the reviewers designated for your Department or Katherine Light, Research and Graduate Studies, 113 University Auditorium

LOG NUMBER 07-471

Form can be downloaded from http://www.kent.edu/roag-alpha/forms/

Please type all information. **HANDWRITTEN FORMS WILL NOT BE ACCEPTED.** Move through the document using TAB or Mouse. Do not use the enter Key. To mark a box, click with the mouse.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Gretchen G. Mettler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: (H) 216-381-6357</td>
<td>Address: 1020 Yellowstone Rd Cleveland Hts, OH 44121</td>
</tr>
<tr>
<td>(W) 216-368-0671</td>
<td>Email: <a href="mailto:ggm@case.edu">ggm@case.edu</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department:</th>
<th>TLCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty Rank/Student Status:</td>
<td>PhD student</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Recent nurse-midwife graduates' perceptions of and experiences with respect, equity and civility as students in preceptor directed clinical experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Project:</td>
<td>☐ FACULTY RESEARCH ☐ External Funded (Agency: ) Include copy of proposal</td>
</tr>
<tr>
<td>☐ STUDENT DIRECTED RESEARCH (Advisor: James Henderson)</td>
<td>☐ Thesis ☐ Dissertation ☐ Course Requirement (Course #: )</td>
</tr>
<tr>
<td>☐ Other (Specify: )</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of Project:</th>
<th>Starting Date: 3/30/07 (But not before approval is obtained)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENDING DATE:</td>
<td>3/30/09</td>
</tr>
</tbody>
</table>

I certify that the research procedures for this project and the method of obtaining consent (if any), as approved by the Kent State University Institutional Review Board, will be followed during the period covered by this research project. Any future changes will be submitted for Board review and approval prior to implementation.

If this project involves approval/permission from other institutions, the principal investigator (and the faculty advisor if the PI is a student) must sign below to certify the following statement: "I/we will not begin research at other institutions before having obtained their permission to do so."

[Signature] [Date: 3/29/07] [Signature] [Date: 4/4/07]

Principal Investigator | Faculty Advisor (IF PI is a student) |
-----------------------|-------------------------------------|

Action Taken:

By REVIEWER:

☐ Level I, Category 2
☐ Level II, Category A
☐ Level III, To Full Board
Project Involves:
☐ Deception
☐ Waiver of Consent
☐ Identifiable medical information

[Signature] [Date: 4/29/07]

Primary Reviewer | Date |
------------------|------|

By KSU INSTITUTIONAL REVIEW BOARD:

☐ Approved, Level I
☐ Approved, Level II

IRB Comments:

[Signature] [Date: 5/3/07]

Administrator, IRB | Date |
-------------------|------|

Co-Reviewer (Level II) | Date |
------------------------|------|

IRB Level III Action:
☐ Approved ☐ Disapproved ☐ Contingent Approval (Comments or Contingencies):

[Signature] [Date: ]

Chairperson, IRB | Date |
------------------|------|

RECEIVED

MAY 1, 2007

3
May 4, 2007

Gretchen G. Mettler  
1020 Yellowstone Road  
Cleveland Heights, OH 44121

Re: 07-477 – "Recent Nurse-Midwife Graduates' Perceptions Of and Experiences  
With Respect, Equity and Civility as Students in Preceptor Directed Clinical  
Experiences"

Dear Ms. Mettler:

I am pleased to inform you that the Kent State University Institutional Review Board approved your Application for Approval to Use Human Research Participants as Level I, Category 2 research. This application was approved on May 2, 2007 and is good for one year.

HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB further requests an annual report and a final report at the conclusion of the study.

A periodic review form will be sent following the marked end date of your protocol or within a year of the original date of approval of the application. Please complete the form and return it. If the project is expected to extend beyond the marked end date, please insert the new expected end date on the periodic review form. If the project is complete and all data analysis has concluded, please mark the appropriate box on the form. If data analysis is continuing, research is considered to be continuing. A copy of the periodic review form has been included for your awareness.

If you have any questions, please contact me at 330.672.2704. (klight@kent.edu)

Sincerely,

Katherine Light  
IRB Administrator
APPENDIX D

American College Of Nurse-Midwives

Division Of Research Letter
June 3, 2007

RE: Approval to contact ACNM members for survey purposes

Gretchen G. Mettler, PhD(c), CNM
1020 Yellowstone Road
Cleveland Heights, Ohio 44121

Dear Ms. Mettler,

We have received your request to access ACNM members with an invitation to complete a survey that is part of a research study entitled “Recent nurse-midwife graduates’ perceptions of and experiences with respect, equity and vicissity as students in preceptor directed clinical experiences.” Thank you for submitting the requisite documents. Our purpose in requesting these documents is to ensure that the rights of ACNM members as research participants will be adequately safeguarded and that surveys mailed to our members are pertinent to the midwifery profession.

We have reviewed your request and accompanying documents and approve your request. Please note: The general statement that is required to be used in your invitation to ACNM members and in any survey advertisements that are for recruiting purposes is: Solicitation of CNM/CM participants for this study has been approved by the ACNM. Enclosed with this letter is the document “Rights of ACNM Members as Research Subjects.” We wish you well in your research efforts.

Sincerely,

Kerri D. Schuiling, PhD, WHCNP, CNM, FACNM
ACNM Sr. Staff Researcher

Patricia Murphy, CNM, DrPH
Chair, DOR Survey Section

342 E. HEWITT AVE
MARQUETTE, MI 49855
APPENDIX E

Question Guide
Questions for the Question Guide

As you know I am interested in understanding your experiences as a nurse midwife student in the clinical setting.

Describe how you felt as a precepted graduate student.

Describe your preceptors for me.

What made a good clinical day?
What made a poor clinical day?
  or
Give me an example of a time when your preceptor “took over”.
How did it make you feel?

What did you like about the way that your preceptor taught you?

What did you not like about the way your preceptor taught you?

What do you wish your preceptor had done differently with you?

What were the most important things that you learned from your preceptor?

What do you think the ideal preceptor would be like for you?
  or
In your opinion, what makes a good preceptor?

When you remember your clinical experiences, if you had to think about the issues of respect, getting along with others, or civil relationships, and being treated fairly and equitably, how would you describe your clinical experiences?
APPENDIX F

Interview Consent Form
CONSENT FORM

Consent Form: Nurse-midwife Graduate's perceptions of Clinical learning

I want to do research on recent nurse midwife graduates’ perceptions of their clinical experiences with their preceptors. I want to do this because we need to better understand the nurse midwife students’ perspectives of the clinical experiences. I would like you to take part in this project. If you decide to do this, you will be asked to participate in one or two interviews lasting about one to 1½ hours. You may also be asked to review portions of your transcript with categories I have developed based on the participants’ experiences to review for accuracy and to verify with me that the categories reflect what you meant.

Participation in this project should not involve any discomfort or risk to you.

Once the interview is completed, you and I will select a pseudonym for you. When the interview is transcribed by me, the pseudonym will be inserted for your name. I will keep a list of actual names with the pseudonyms is a special place, different from where I store the transcripts. No one will ever know about your participation, unless you tell them.

If you take part in this project I will give you a $25.00 gift card for a bookstore to express my appreciation for your time and efforts. Taking part in this project is entirely up to you, and no one will hold it against you if you decide not to do it. If you do take part, you may stop at any time.

If you want to know more about this research project, please call me at 216.381.6357 or 216.368.0671, or you may contact my advisor, Dr. James Henderson at 330.672.0631. The project has been approved by Kent State University. If you have questions about Kent State University's rules for research, please call Dr. Peter C. Tandy, Acting Vice President and Dean, Division of Research and Graduate Studies (Tel. 330.672.2704).

You will get a copy of this consent form.

Sincerely,
Gretchen G. Mettler, CNM, MS

B. CONSENT STATEMENT(S)
1. I agree to take part in this project. I know what I will have to do and that I can stop at any time.

__________________________   _____________________
Signature              Date

P.O. Box 5190 • Kent, Ohio 44242-0002

162
APPENDIX G

Audiotape Consent Form
AUDIOTAPE CONSENT FORM

I agree to audio taping at________________________________________________________

on______________________________________________.

_______________________________________________________________________________

Signature Date

I have been told that I have the right to hear the audio recording before it is used. I have
decided that I:

____want to hear the recording ______do not want to hear the recording

Sign now below if you do not want to hear the recording. If you want to hear the recording,
you will be asked to sign after hearing it.

Gretchen G. Mettler, CNM, MS and other researchers approved by Kent State University may
/may not use the recording made of me. The original recording or copies may be used for:

_XX_ this research project __XX_ teacher education _XX_ presentation at professional meetings

Signature Date

Address:
APPENDIX H

Interview Summaries
Ann Interview summary

28 y.o. female.
Married during graduate school
Worked as an RN full time on L&D for 1 year, through first 1 ½ semesters of MSN program
Clinical sites included family planning clinic, solo CNM practice (2 1 busy, one not; one medicaid, one not), solo CNM practice for L&B, solo CNM practice in WVA for integration; MD for primary care.

Described feelings of inadequacy for a “bad” clinical day; overwhelmed, lack of support, and higher expectations of clinical abilities.
Described in first experience having a nice preceptor who threw her in the fire rather than leading her and helping; probably thought she would ask for help if she needed it.
She talked a lot about relationships both with clients and with preceptors.
Communication with preceptor made experiences wonderful. Human interaction.
Best preceptors were
• positive,
• encouraging,
• treated her as an equal, not much as a student, more like a partner, colleague;
• didn’t treat her as inadequate.
• Made her feel she is capable of doing anything the preceptor could teach her.
• Sought input
• Thoughts are respected
• Critique, pointing things out, constructive criticism
Happy to learn from the student herself, welcomed into her practice. As a student you can share and teach preceptor something; ideas won’t be shot down.
Acknowledges it takes effort, time, and energy to teach a student when precepting. If having a bad day, preceptor did not want to be bothered with the student.
A non-supportive preceptor
• would not let her do a birth.
• Another sent the message of “how stupid could you be?”
• You can’t do anything right.
• Time management issues are a problem, and sometimes preceptors take over because of that.
• One preceptor was an MD, felt that physician nurse relationship was difficult. Should be precepted by someone of a similar background. Difficulty understanding NP students were as capable as med students.

Trust. Allow student to talk with clients
Prove you are worthy (of the trust) comes up over and over, especially in talking about integration.

- Trustworthiness.
- Rising to the occasion, or exceeding the preceptor’s expectations, allows student more autonomy.
- Could not prove worthiness to the MD, but did gain his respect, as least for gyn issues.
- For one preceptor was worthy when her charting met her standards.

Preceptors demonstrated
- caring aspect of midwifery.
- Humility;
- open self up;
- accept when you’re wrong, acknowledge and fix it;
- say you’re sorry.
- Listening;
- interacting with other colleagues;
- being confident in self.
- Ask why, wonder.
- Learn together, look things up together.
- Flexibility,
- humor.
- Ability to make student feel relaxed and let the student try different things.

All relationships of student with staff influence the student’s education (housekeeping on up)

How a preceptor introduces the student sets the stage for how the client views the student – it’s a big deal to the student. Saying “she’s just a student” has a negative impact on the experience, “people don’t trust students, no matter what”.

Equity, not much in the first semester, a lot by integration; couldn’t feel the “equal” of someone who had been practicing for some time. All preceptors treated her as they did others, and better than they treated the patients: demonstrated interest in her as a person.

- Preceptor recognizes where the student is and brings her along to another level.
- Equality, respect were present.
Bertha Interview summary

28 y.o. female.
Worked as an RN full time on L&D for 1 year, through first 1 ½ semesters of MSN program, prn thereafter
Clinical sites included suburban large midwifery practice, VA Medical Center AIDS clinic for primary care, and…, suburban small midwifery practice for L&B, independently owned CNM practice.

Received 1 to 1 attention, preceptors open to her strengths and weaknesses.
Felt like a kid again,
- vulnerable to the very end,
- didn’t know anything,
- hard to ask questions because I should already know this.
- Child role, still an adult, hard to find middle ground.
- The preceptors did a good job of treating her like an adult
- Unsure of balance between taking initiative, and feeling too bold, too forward, or unsafe.

A good clinical day didn’t feel like an idiot the entire day.
Most of the Preceptors were sincere and up front
One preceptor never said anything bad, never criticized, didn’t put into writing, even though she asked often for feedback. But at site visit told instructor she wasn’t at the right stage yet; caused a lot of anger and hurt. Felt betrayed. “I felt she was being honest, but she wasn’t”; what other things she wasn’t telling me that I needed to be working on, did I grow that semester? Not getting right feedback. Preceptor worried about what the next preceptor was going to say about HER. The student observed the preceptor talking about others behind their backs, while being very nice to their faces. Has a hard time telling people what to do to run the office smoothly; talks about all the other midwives but one. The lack of honesty backfired later in the semester when the preceptor said she was doing fine, was she really?
Good feedback from another preceptor about avoiding making mistakes. Was a good guide, helped her to think about her learning. Another preceptor had long conversations about role development to enhance stud’s experience, gave midwifery wisdom
The TONE from Pat – felt cornered, and what ever she did was going to be wrong
One preceptor was pretty blunt.
One preceptor threw things one day and fired people. Student was scared, didn’t want to go back, but had most of the semester to work things out.
People that love ob and those who don’t.
- Those that do are respectful towards the patients, the situation and are comfortable people.
- It almost a personality thing, if they’re going to be like this in the office and with patients, be like that everywhere.
One preceptor a little condescending, esp towards patients; doesn’t treat them as equal; but respectful to student
Less experience a preceptor has, the more they need to get their “hands” in things. It becomes the preceptor’s experience, not the student’s.
Clear who had taught/precepted before, they thought about the way in which the student learns.
- Didn’t give a bunch of information, would give bits as they saw she was ready;
- paid attention to her and her learning.
- Grew her and developed her as they taught her.
- Patient,
- didn’t make her feel bad when she made a mistake,
- see holes and have me acknowledge what they are and need to do to get to a higher level.
- Talk about the clinical picture; had a more wholistic perspective of the entire pt., and broader world views.
- Experience, open minded, flexible, dedicated, soft, not a push over, but not rough around the edges, approachable, guide. Understanding of teaching. know how I learn, even when they didn’t know me.
I don’t want to be fake to my patients. I have a fundamental love for midwifery.
Communication. Student needs to communicate her thoughts to preceptor, preceptor needs to understand student is thinking.
Don’t use student to fill staffing shortages. Treat student fairly, don’t take advantage of student
Even “bad” settings have a lot to offer. Learned a lot about group issues, controversy, and doctor-midwife issues.
Student’s job is to prove to preceptor that you’re good enough, you know what you’re doing. Felt most had to prove herself to Erin. Feel it yourself, that you are worthy. Prove to preceptors, even if you feel you’re faking it.
Preceptors need to know where I’m at, check in with me, if I had questions or doubts, give respectable and truthful feedback.
Respect that I am an intelligent person.
Carla Interview Summary


Small class, newer program. 
Midwifery Clinical was not a good experience (6) Was preceptor’s first student (958) 
Primary care was a good experience – learned a lot. Kinder; helpful at teaching 
Midwifery preceptor Never asked anything about her background or philosophy. Said “I’m going to take all the labor and delivery nurse out of you” (20) 
Big age different, preceptor was young enough to be the student’s daughter. 
Student thought we can work it out, but never did “She hated me” (39) 
Would tell students, she’s been doing labor nursing since before I was born, but not in a nice way. (361), 
maybe made preceptor uncomfortable. 
Student knew back up doc for >25 yrs, it bothered her they had history. 

Made it clear to student no matter what she did, it wasn’t what the preceptor wanted. 
Compared her education program with the students – wanted things the way her program had been. 
Didn’t seem to value students skills, or want to build on them. 

Preceptor complained to the school a lot, did not fail, but complained 
Did not give the student very good feedback, deducted points on clinical eval, but couldn’t say why (1070) 
Student was proactive, developed a performance improvement plan, assumed responsibility for parts she thought she could control. Didn’t make a difference (1059) 
School did many site visits in office, thought her skills, technique, interactions were fine. 
Reported student for not being involved with her pt, after 24 hrs of labor, when preceptor didn’t call back up at 10 pm for section and waited until 6 am. 
Was not honest in her interactions and evaluations 

As L&D preceptor she brought her newborn to the hospital – nurses babysat. Preceptor was distracted. 

Last 2 births with her, student knew baby was OP, preceptor didn’t (G5 pushed for 3 hours); preceptor didn’t notify MD of face presentation until crowning. Not setting professional example for student. 

School withdrew student from the site after nearly a year 
Never could produce guidelines – they were always being worked on at home. 
Student took Tharpe. She (CNM) practiced without anything.
Integration went to a different practice.
Integration preceptor when asked by student what her perfect practice would be said I’d really like to go to medical school (317-18)
Had guidelines, organized, routines, what expectations were.
Given appropriate feedback (1141)

Thinks her expectations were unrealistic.

Bad clinical days: preceptor was angry or frustrated with her, and not being able to get feedback.
Was told she did good labor support.
Expectations changed from day to day. (shifting sands)
Manipulated L&D staff, set 1 nurse against another, changed the rules
Deception
Not interested in staying current A narrow scope of interest

Equitably treated – those who treated others well treated her well, those that didn’t, didn’t treat her well.
Cried before going to clinical; afraid of 32 year old preceptor
“I don’t know that the entire time I was with her she gave me one positive stroke” It was either negative or nothing.” (829-831)

Civil, but felt as though never connected on any level.
Sometimes when asking a question she’d cut her off, didn’t listen to the question.

Two different faces, the face the clients see and the face the student and staff saw.
Touchy feely, down home with patients.
Not interactive with others.

Ideal preceptor would truly love to teach, asks questions, mentors
Denise Interview summary

Late 20s woman
Worked as an RN through school. Had 5 years L&D experience prior to returning to school.
Clinical sites, primary care with a NP; Antepartum in an MD clinic, IP with a private midwifery group that also had her do office visits; integration with a large university hospital practice.

Repeated overall had really good experiences. Welcoming. Happy with a lot of teaching. The experiences and situations she was given, she learned from.

First preceptor
- Harsh
- not welcoming
- taught by scolding
- learn by embarrassment.
- Learned out of fear of being scolded.
- Was talked down to in front of the pts a lot. (454, p. 10). Grabbed the form out of her hand, sarcastic to the student in front of the pt. rolled her eyes, injected snide remarks (p. 11).
- Then towards the end became a great student never knew what to think *(Shifting Sands)*
- Improved level of respect for student by the end (p. 15, l, 654-655).
- Not condescending to the pts. Don’t talk to her before the cup of coffee.

AP practice with physicians
- sent off w/o much supervision
- worked with the rotating residents in a predominately Spanish speaking setting – she didn’t speak Spanish.
- Limited feedback,
- respectful of nursing background and being a midwifery student; She thought they felt because she was a nurse before they didn’t need to supervise her much.

Addressed issues residents didn’t address

IP small group of CNMs and NPs pts and midwives were welcoming. Did Antepartum care because births didn’t come often, so got direct feedback from the midwives. They stayed flexible for what she could do or learn. Always polite, even at 2 am.
Midwives invited her to their Christmas party/meeting.
Integration welcoming to have her as a student. Shared time in pt with med students; but she had good rapport with residents and physicians.
Physicians treated her better than they treated the residents.
- Would say mean things to the residents, but never to her.
Preceptors in integration expected her to be up front about what she knew or didn’t.
One midwife was condescending,
Is that way with everyone and all previous students.
Even when things were right, there was still something wrong.
Passive aggressive nature of conversations.
Feedback was always negative: “you did really good, but that’s not how you would…” (line 271-272, p. 6) That’s not how I would do it (line 274-275, p. 7)
Never said it was a great job. That was good, but it was bad (p. 8 line 321)
You need to do more.
Primary preceptor at that site was good,
mix of laid back personality
understanding the student,
know where she is with things – have to be sure person you’re precepting has
integrity to tell you what she doesn’t know.
After seeing a patient, reflected back, how did you feel about that.
Let student identify strong points and weaknesses.
Preceptor would say you did a great job, is there anything I could help you with
identified good things stud had done
For next time try to think about this. Never anything is wrong. (315. p. 7)
There to help the student, provided feedback and constructive criticism. Centered around
the student’s learning, not the preceptor’s need to show off. Added to student’s learning
for the next time.
I don’t like making mistakes, and not feeling I know things (359-360, p. 8)
I like team approach
Carry the pager, check with the midwife, make the plan, double check with someone;
better than having someone looking over the shoulder.
Poor clinical day, don’t feel like doing a good job
CNMs treated her as they treated others.
Good relationships with pts, staff, nursing, communicated to student.
Team work, respectful, everyone has a role to play, no right or wrong,
respect the other opinions.
One person talked to her as if she were her child. – didn’t like it, it didn’t bother
her
Student notes when you treat people the way you want to be treated is noticed by just
about everybody, and appreciated.
Didn’t like the novice role.
Preceptors didn’t interject. Let her do it. Understood where she was at.
Things I came up with to create a good learning experience. Was part of guiding what it
was I needed to learn.
Feeling of proving worth came from the patients (p. 19), and to the nursing staff in
hospital (p. 16). Nursing staff at the hospital was hardest, harder than physicians.
** being very conscious that everything you say is going to be taken personally to some
degree or another (998-999, p. 22)
Preceptor needs to realize students have a lot going on, unless something is totally neglectful and dangerous, approach in manner of learning for next time, what are the reasons to do it another way (Not just policy)?
Emily Interview Summary
27-28 yr old RN for 3 yrs before program

A VERY good experience.
Always treated with respect by preceptors and others
Treated professionally and held to a graduate level, to be accountable for her actions

Felt childlike in the first 3 weeks of each semester until got to know the setting,
paperwork, people, system.
First semester didn’t know anything, so have to act like a child: keep mouth shut, watch
what the preceptor is doing and then imitate
Dependent on the preceptor for any sort of satisfaction or happiness
After the first few weeks moved into a more professional relationship

First preceptor selected pts that were better for her learning (respected her abilities)
Respectful of the amount of time she needed with clients.
Answered question; kept the student oriented to the big picture and prioritization.

Second preceptor “just great”; treated people professionally & w/respect
Did not make stud feel stupid or incompetent. Acted as a guide
No question was inappropriate, and answered appropriately. Very long time working as a
CNM, lots of wisdom, never made student feel inferior.
Knew how to teach: led by example.

Primary care preceptor expected things at a high level.
Had problems with answering questions and student understanding the answers; Student
thot she was frustrated with her questions
Raised the bar each week for competence and expectations

IP thorough experience. Preceptor took the reins for first few pts, had her watch a couple
of births, student felt frustrated, because she’d been watching for 7 years.
A slow progression; gained skills slowly.
Talked her through 4-5 births when “my hands didn’t know what to do.” (138)
Prissy about stitching.
Pushed her to make decisions – helped to grow, because didn’t feel ready then.
Required a level of perfection
Other preceptors gave opportunities to make own decisions, or didn’t glove for the birth,
scary during, but a boost of confidence later.

NB assessment guided own learning

Integration preceptor was tough, has a sense of humor, able to teach, high expectations.
Guided her through the transition to becoming a CNM
“Put on the spot” (393), make a decision w/o consulting with preceptor first. Preceptor pushed her to do that.

A good day came from not feeling incompetent because of my own stuff – not the preceptor (180).
When you’re efficient, know what you’re doing.
A level of confidence.
At the beginning of each rotation before comfortable with preceptor and site, more poor days.
Most of the good and bad came from within this student, not from preceptor.

A good preceptor is patient, answer questions, deal with inefficiencies, and lack of abilities.
Respected student enough to treat her as an adult and grad student, not an undergrad.
They valued my input (239-242).
Be respectful to student and pts, sees big picture, and keeps student focused on that. If messing up can steer in right direction w/o being mean.
In integration there were some power struggles.
She was sometimes more aggressive than used to in how she spoke (296). While she needed to hear it, didn’t feel like she was learning, and was uncomfortable; but didn’t make that mistake again.

Never felt abandoned or neglected.
Preceptors cared about how she was doing.

Preceptors were consistent in treatment of all people, professional, well rounded, very nice.
She experienced high levels of respect, equity and civility in every situation.
Preceptors happy in roles, satisfied with jobs, so can be nice to pts and student (345-351)
Didn’t get much supervision, occasional constructive criticism would have been good.
Felt preceptors had too much confidence in her at the beginning.
Invested in her learning (362) – called her at home about pts, find clients to strengthen her weak area (592)
Wanted to make sure she had the best well-rounded experience.

Learned everything from preceptors:
How to talk w/ pts, professionalism how to run an office, reimbursement, documentation,
emphasized teaching, pt ed.

Feedback was honest, concrete about why doing good, or not, and areas needed to work on, appropriate, timely

Notes personalities play into being a good teacher.
Felt preceptors thought she was better than she felt. Her confidence wasn’t as high.

Very close relationships with them after spending “every waking hour” with them (617). Thinks precepting is rewarding as well as a sacrifice.
Felicity Interview Summary
26 yr old Student

Eyes and ears are watching
- Be gentle with words (1443)
- Know that you’re being observed
- Being catty about other midwives, student also then judges CNM (996)
- Shared inappropriate things about others that wouldn’t help develop trust in their abilities.
- Midwife-> midwife nasty talk about physicians (1019)
- Midwife-> physicians ok (sucking up)
- Midwife-> generally ok
- Midwife-> pt talked down, esp is English not native language.
- Midwife -> nurses depends on CNM’s identity (if hadn’t worked as a nurse/CM more physician nurse than nurse-nurse)

Very small midwifery community/but even smaller midwifery student community (don’t talk about other students, I may know them)

Class/cultural issues
- School’s reputation - prejudice against a particular school’s program
- Preceptors Hispanic/A-A – student Caucasian
- Personality clashes, but student still needs to learn from preceptor.
- Tension that goes beyond work.

Preceptors give gift of time and energy, wisdom and experience
- Students aware of gift; preceptors not aware of student’s respect for the gifts

Midwifery educational time is precious; don’t waste it (1275)
- Exhausting to learn each new preceptor’s preferences, expectations; how to deal with each new site’s routines, paperwork. Negotiations of these issues
- Look at all the possibilities for finding time to “teach”, talk w/student, review what should be working on.
- Preceptors need to have respect for the role of teacher.

Think of student, not as student, but as a future peer.

Best preceptors are “the ones who asked me” (1180)

Becoming a “Trouper”
- Charting alone
- Seeing pts alone
• Asking questions of preceptors; never them asking of her.
• No feedback; multiple preceptors at each site for first 2 semesters. Having multiple preceptors meant no one or 2 could see her progress.

Preceptors
• Sweet, endearing, chatty, hurried, informal, insensitive to pts and student,
• “They were mean to me” (267)
• Preceptor wouldn’t speak to her when eating together – read a book. “0 interest in me as a person” (285)

Student questioned the midwife’s command in front of the patient (315) – yelled at the student in the hallway, talked about her to other staff. Felt like a personal assault (349). Was second instance w/ preceptor – first was asking an attending about UTI treatment; was told to never talk to an attending again.

Good preceptors focus on women; not of merely getting through the shift, or seeing all the clients. (404)

Invisible
• Inconvenience, ignored, not introduced, not there, not a participant
• No effort to usher me into the community of the L&D floor (449)
• Intimidating – couldn’t ask to be included (privileges) (497)

Had a preceptor in integration who had a hard time letting go, recognized it, and eventually stayed out of her room until the end of the vs. (548)

Have student’s interests in mind
• I’m here for you – happened at the end of integration (583)
• Ask the student for her plan
• Propose hypothetical situations for alternative plans.

Left out to dry, unsupported
• Poor communication between preceptor and student (stud didn’t know where preceptor was)

Delicate balance between supervision and independence
• The school she was from was her identity – not her identity as a person – wanted to form a bond with the preceptors.
• Concrete, specific feedback
• Good sense of humor, and ability to keep things in perspective (keeping small mistakes minimized, emphasizing big mistakes) (796)
• Many were preceptors who had no desire to have a student - it showed.
Proving herself every single minute, being “on” all the time.
  - 9-week job interview, changed her position, less likely to ask questions (“I should know this” – don’t want to display ignorance)

No big picture from the preceptors – get the job done
  - It was about the minutia.
  - Everyone gets seen – safety over quality.
  - Efficiency versus safety (do vs in 10 minutes, or not make mistakes?) (877)
  - Endurance – get through shift/ get through career (981)
  - Expect the student to do things the way the preceptor does them

Invited to attend AP-GYN sites Friday morning breakfasts. “a really great way to know them as people” (relationship thing here, again) (915). Also contributed to big picture and understanding the business side.
Linda Interview Summary

45 y.o. woman Has previously been a teacher and a secretary.

Felt like a child – didn’t know what she was doing.
Felt like she was treated like a child.

Thrives on responsibility
Didn’t feel weight of responsibility, as she would if seeing her own patients-didn’t have ownership. Shirked, because it was someone else’s responsibility.
Didn’t push herself to go far, as if she had “been on her own”
Always showing the other person what you can and can’t do. I have to do someone else’s work today, it’s not mine.

Didn’t feel she could speak up and ask for more responsibility.
Felt tolerated as a student.
“Marking time.” Didn’t like to ask questions of preceptors who didn’t like her program-marked time on those days.
Having to face a preceptor every day

Preceptors responsible, professional, thorough. Respectful
First semester flipped through charts for student, didn’t teach her to chart well.
Some preceptors had judgments against students from her program, so had to prove herself and the school to them.
One preceptor had great respect for the student’s abilities and allowed her to be on her own in the last semester.
“I am a student. She doesn’t trust me. She is going to do it herself”.
The last semester one preceptor’s hands were always there for the birth.
Student didn’t know staffing on L&D

Felt very tired through the program, and esp at the end.

One preceptor didn’t want to talk with the student-lack of civility. Said her program was at the bottom of their list.
Example on lines 961-989 of her not talking, purposely ignoring student. No respect for student.
However, is equitable-might have done it with anyone. Other midwives confirmed that is the way she is.
Unprepared for another preceptor who chided her. Then she wrinkled up her nose and looked down. Student admits she needed to be talked to. Later in the semester commented that student had improved a lot and she was happy with how it was going.
Allowed stud to see pts on her own. (trust)
Good feedback. Ongoing. Supportive, not trying to destroy her. (297)
Knew from students who had had trouble that preceptors would let you know what you
need to improve.
Usually if asked a question got a good answer.
Preceptors asked questions to know what the student knew.
A good preceptor challenges me and asks questions to make sure I know.
First semester they hardly asked questions. They just wanted to get it done fast to go home.
Didn’t have the chance to ask questions, on to the next patient quickly.

Didn’t allow the level of independence she craved. Sometimes just watched the preceptors all day.

Preceptors focused on women, showed the student importance of the woman making the decisions.
Learned communication with doc and others very imp.-learned collaboration

One preceptor very interested in making sure student had “resources”. A different type of respect? Super helpful too much for student. Other preceptor did normal business with student, didn’t change.

Proving worthy to one preceptor, only, but didn’t try, because didn’t feel the other would recognize it.
Avoided certain preceptors she would have to prove things to, because they wouldn’t believe in her.

Preceptors generally treated her as they treated all others (equality)

Student may not have respect for self or others given her remarks, and also talking about women as one vagina after another.
Maria Interview Summary

Native of Canary Islands. Came from Spain to NYC to finish BSN. Stayed to work for 3 years and entered midwifery school. (makes her about 26 years old)

Mostly positive experiences; preceptors explained what their expectations were. Explained about some confusion sometimes because different people want the student to do things in different ways, but after getting to know each one, was ok.
Must be open to change
Had more than 15 preceptors.
2 were Hispanic, could communicate in their own language with her., had better understanding of “why”, and pt’s level.
A preceptor helped her with “everything, answered all her question; another showed her how to be with a patient.
Liked preceptors to listen to her and the plan all the way through, then give her their plan, better learning that way. Better to talk before entering the pts room, and set everything up.
Preceptors ages varied from her grandmother’s age to young, but most in 40s.

Felt preceptors all respected her. Maybe the new one had issues.
Felt all preceptors treated her and others equitably (except one)
Civility – one preceptor (only) talked about others and disparaged them to docs and staff behind their backs (so student always did what she said to do)
Also one preceptor complained about the patients (she has the same STD!), funny with student, but “kind of mean”

One changed her whole life.
She was in home-birth, pvt practice, could spend an hour with pts.
Showed her techniques (was 1st semester preceptor), had tons of books to read
Very sweet with everybody, and saw grandmothers, mothers and daughters (whole families she had birthed)
Gave time to everybody, gave time to cry, made them feel comfortable. Had pts participate more in their care.
Was sweet with everyone. She asked pts permission to have student. They always said yes. She asked pts to give M feedback
Preceptor aware of her need for numbers, but at same time said “you have to do this slowly, you need to be confident” (120-121). She was happy with what she was doing.

Loves being told she was doing good. And when preceptors gave feedback. Love when doing your best, and it’s acknowledged
12 Hours spend worrying, trying to do your best. Trying to be nice to attending, pt, preceptor and all staff, but nobody tells you anything
A chief resident screamed at her and then told everyone else on the floor how crazy she was for putting the pt and baby at risk. Preceptor supported student, asked resident for information to support her accusations, and told her until she could produce it, the student was fine. This resident made her cry twice.

All preceptors supported her.

A new preceptor was anxious and interfered a lot. Asked her to talk a lot. Student felt, I haven’t done anything bad with anybody else, so why don’t you give me time? (258-260) Feels it’s hard to be a preceptor, older, more experienced midwives were her better preceptors

One preceptor was aggressive with pts, and told the student to do a lot of interventions because she was learning. Didn’t feel strong enough to resist. Have to prove all the time that you are good, constantly, stressful, always have on your best face. It takes a lot of energy and time, all the time. But didn’t have to prove she was better than the last student or anyone else.

A good preceptor gives time to think, asks questions, can demonstrate thinking is on the right track. Gives the preceptor confidence to let her do it herself.

Learned to love the profession from the preceptors, how dedicated they are, working on things they love.

A midwife complained about the hospital policies, the more she complained, the more tension developed, people “were against her”, her job was more difficult

Sometimes used as an extra hand in the clinic, not much supervision, esp in second semester. Had to find CNM to consult with. Learned quickly

Sometimes felt in competition with preceptors, that they needed to show her they knew more than she did (younger ones., 2 or 3 years out) (737)

Difficult interview. Conducted in a fairly noisy coffee house with music blaring. I don’t think she often understood the questions and what I was trying to get at.
Rachel Interview Summary

Late 20’s, mother of 3 children, married to a chiropractor. Practiced as a nurse for 4 yrs prior to midwifery program, and then one more year while in program. Stopped in 2006

Felt Honored to be precepted.
Midwives treated her with respect and she felt “encircled” (12) with caring. Felt like she had a midwife to transition her through her education.
Exciting to see someone (WHNP, first preceptor) who was excited about what she does – passionate about women’s health.
Taught her how to better relate to people
Respectful of her beliefs as a Catholic suggested she counsel with her priest about family planning (614) Learned to be responsible for presenting options and it’s their moral decision to chose. It gave her peace
Second placement learned a lot about cultural diversity, and to think on her feet.
In IP was with a “legend” who is humble, quiet and is about serving women. Practices religion in what she does.

Noted how small the midwife community is (and always on a job interview)
Noted by the time she was in integration she was more critical of practice because she was transitioning professionally. Step up and speak up accept higher responsibility.

A good clinical day was reading about something and then having it in clinical.
Continuity between antepartum and labor and birth, established relationship
Able to juggle studies, do the physical assessment, and still have energy for the family.

Poor clinical day knowing limitations of the clients resources.
Sometimes can’t connect with everyone.
Know not everyone is the same culturally, financially, different values

First IP birth when the preceptor’s hands were on her hands, she was disappointed. (line 325) Recognized it was a trust issue, that the preceptor had to know that she knew what to do. These are the ropes you have to go through (337)
Never had a preceptor take over or felt offended.
Learned about the beauty of consulting with physician. They can agree and not take over.

Felt like the eager beaver; felt like a kid again in that she felt youthful and excited, with butterflies.

Loved being asked questions because had to think on the spot.
Preceptor made a safe environment to be quizzed in and to not know. (376)
Learned it’s ok to say I don’t know.
Preceptors need to remember the multiple demands a student faces: studies, classes, family and clinical.
First preceptor expected her to sit and watch her chart until 5 pm when they left, even though the student was done. (RESPECT)
Suggests that preceptors honor the student’s time.

Felt she had to prove herself to the medical community.
Learned to talk out loud to tell people what she is thinking
Had to prove herself to families (473)
The preceptors “almost feel you out” to see do you have it in you to do this? (908)
Show the preceptors she’s dedicated to learning to be a great midwife. (916)

Inequity: saw a preceptor who treated everyone well, but treated doctors very well
Two midwives were breaking up the practice and put student in the middle. Patients would ask how can I chose? (505)
One CNM undermined the other, didn’t like her skills, question her, talked about her to staff, called in orders to L&D. Then the staff started to question the CNM’s skills, assumed she wasn’t doing the right thing.
The midwife leaving couldn’t understand why the student would stay (841)

A good preceptor has the desire to pass on the skills and traditions of midwifery. (557)
Connect on wanting to serve women and families.
Have high expectations because it’s about the pursuit of excellence.
Treat everyone equally and honor them. (684) Can’t fix everything, but can try to empower (696)

Felt very respected.
Felt uncomfortable (with preceptors) sometimes, esp when the 2 were arguing.

Noticed things shifting when working with the 2 midwives who were separating.
The midwife leaving called her in for a birth at the hospital, although the preceptor knew she didn’t have her privileges any more, because she wasn’t working there.. It put the student squarely in the middle, put her out on a limb medico-legally.
After consulting with clinical coordinator at school student realized her actions don’t reflect just on her, but on midwifery.
At the worst of the arguing, didn’t like going to clinicals

I’m getting in and I’m getting this done (933)
REFERENCES
REFERENCES


